# STANDARDS FOR HEALTH PLANS PROVIDING COVERAGE IN THE MEDICARE PROGRAM

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

AND THE

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON COMMERCE

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## HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

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JULY 27, 1995

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**Committee on Commerce Serial 104–71**

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# STANDARDS FOR HEALTH PLANS PROVIDING COVERAGE IN THE MEDICARE PROGRAM

THURSDAY, JULY 27, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
JOINT WITH COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
*Washington, DC.*

The Subcommittees met jointly at 10:17 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee on Health of the Committee on Ways and Means) presiding.

[The advisory announcing the hearing follows:]

# *ADVISORY*

## FROM THE COMMITTEE ON WAYS AND MEANS

### SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 20, 1995
No. HL-15

CONTACT: (202) 225-3943

## Thomas and Bilirakis Announce a Joint Hearing On Standards for Health Plans Providing Coverage in the Medicare Program

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, and Congressman Michael Biliarkis (R-FL), Chairman of the Subcommittee on Health and Environment of the Committee on Commerce, today announced that their subcommittees will hold a joint hearing on standards for private health insurance plans seeking to participate in and provide coverage to beneficiaries under the Medicare program. **The hearing will take place on July 27, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include representatives of private organizations that develop standards for quality health care and accredit health care systems and plans as meeting those standards; representatives of state insurance regulators who assure the financial solvency and other critical aspects of insurance company operations; government oversight organizations that have reviewed the "state of the art" in setting appropriate standards for health plans; and representatives of private health plans. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committees and for inclusion in the printed record of the hearing.

BACKGROUND:

Currently, the Medicare program serves over 37 million beneficiaries, the majority of whom receive services under a Federally-administered system of paying hospitals and physicians directly for their services. However, under the auspices of the Medicare program, a growing number of beneficiaries are interested in and enrolling in organized health delivery systems, such as health maintenance organizations, that provide health services in local communities.

The Committees on Ways and Means and Commerce are committed to responding to this interest by improving the choice of plans available to beneficiaries. In so doing, the Committees are equally committed to assuring that private plans certified to provide services to beneficiaries meet the highest standards of quality in health care and accountability in their marketing and other business practices.

FOCUS OF THE HEARING:

The hearing will focus on two important matters. The first is to obtain testimony on the full range of standards currently applied in the health care system, both public and private, with emphasis on the needs and unique requirements of the Medicare program. The second is to take testimony on how best to discharge this responsibility and to explore what the appropriate roles are for private sector entities, the states, and the federal government. In particular, the Committees are interested in investigating the feasibility under the Medicare program of entering into agreements with states and with private accreditation organizations in order to balance the proper discharge of these responsibilities with minimal regulatory burden and intervention.

WAYS AND MEANS SUBCOMMITTEE ON HEALTH

**DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least twelve (12) copies of their statement, with their address and date of hearing noted, by the close of business, August 3, 1995. Six (6) copies should be sent to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Six (6) copies should be sent to Darlene G. McMullen, Chief Legislative Clerk Commttee on Commerce, U.S. House of Representatives, 2125 Rayburn House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Ways and Means' Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

**FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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Chairman THOMAS. Good morning.

It is a pleasure to welcome you to a joint hearing of the Health Subcommittee of the Ways and Means Committee and the Health Subcommittee of the Commerce Committee. I would like to welcome our colleagues from the Commerce Committee.

I consider the subject of today's hearings to be important to successfully providing more health plan choices to Medicare beneficiaries. I think the situation is clear: The Congress and the administration have an obligation to Medicare beneficiaries to assure that they get professional high-quality medical care. That applies to care provided through the fee-for-service system, as well as coordinated care plans such as health maintenance organizations and other health plan arrangements.

As we explore expanding the range of plan choices available to Medicare beneficiaries, we are committed to assuring that any private plans certified to provide services meet the highest standards of quality in health care and accountability in their financial and business practices.

This hearing I think has two major objectives. The first is to obtain testimony on the full range of standards possible, both public and private, that are currently applied to health services and plans. In this regard, we are particularly interested in evaluating the information in the context of the requirements of the Medicare Program.

The second goal I think is to receive testimony on how best to carry out the responsibility of developing and implementing standards for private health plans participating in the Medicare Program. We intend to explore what the appropriate roles are for private organizations and for both States and the Federal Government in this process.

In particular, I think we want to investigate the feasibility under the Medicare Program of entering into arrangements with States and private accrediting organizations to handle many of these kinds of tasks. We feel strongly about the importance of discharging these responsibilities with the absolute minimum of regulatory redtape and burden. I look forward to the testimony that we will receive today.

[The opening statement of Mr. Ganske follows:]

OPENING STATEMENT OF HON. GREG GANSKE

Mr. Chairmen, thank you for calling this hearing today. It is a pleasure to join my colleagues on the Ways and Means Committee as we continue our investigation of the Medicare Program and ways in which it can be improved.

Over the next few months, I expect the Members of these two panels to work quite closely on proposals to preserve, protect, and strengthen Medicare. With bankruptcy of the Hospital Insurance Trust Fund looming in 7 years, we will have to take bold steps to guarantee that Medicare will provide benefits to our grandparents today and to our grandchildren tomorrow.

The subject of this joint hearing, plan standards, is especially appropriate. Most Medicare reform plans which we will consider create incentives for elderly beneficiaries to enroll in managed care plans. As we move in the direction of more managed care for Medicare, we must pay special attention to the unique health needs of this population.

Before we endorse managed care as the silver bullet of reform, Congress must be satisfied that HMOs and other coordinated care networks will fully meet the health care needs of the elderly. While I believe that managed care must be an option for the elderly, I will support efforts to guarantee that these plans adhere to certain patient protection provisions. I look forward to working with my colleagues on both panels and both sides of the aisle to ensure that our efforts to protect the financial future of Medicare do not threaten the health of those who depend upon Medicare.

I thank the Chairmen and look forward to the testimony of the witnesses.

Chairman THOMAS. At this time, I would recognize the gentleman from Florida, the Chairman of the Health Subcommittee of the Commerce Committee, Mr. Bilirakis.

Chairman BILIRAKIS. Thank you, Mr. Chairman.

I, too, am pleased that we are holding a joint hearing this morning. As the two Committees in the House responsible for the Medicare Program, it is appropriate for us to meet together to discuss the important, but difficult issues of standards for health plans and the Medicare Program.

In addition to making the Medicare Trust Fund solvent to assure the continued existence of the program, one of our primary goals is to increase the choices available to senior citizens.

In today's health care market, new types of plans are constantly emerging. These new plans are available to those in the work force, but are typically not available to Medicare beneficiaries. As those currently in the work force become Medicare beneficiaries, we want to make that transition smoother by permitting them to remain in health plans with which they are familiar.

Currently, there are only two options available to them, traditional fee-for-service and HMOs, and HMOs are not available, as we know, in all areas of the country. Even where they are available, many seniors are unaware of this option.

As new types of plans enter the Medicare market, we must ensure that they are providing quality health care to seniors. In addition, these plans must be financially secure, so seniors will not be left without health coverage. Designing these standards will not be easy. We must decide on standards, whether or not the same standards should apply to all types of plans, including HMOs, PPOs and PHOs. Equally important is determining who should be responsible for enforcing these standards, the Federal Government, the States, private entities, or some combination.

Our witnesses today will describe for us the current requirements for the various types of health plans. Several of our witnesses will propose standards which they believe should apply to the different types of health plans that may be available. Along with the other Members, I look forward to the testimony of our witnesses and welcome your input.

Thank you very much, Mr. Chairman.

Chairman THOMAS. I thank the Chairman.

I will now recognize the Ranking Member of the Health Subcommittee of the Ways and Means Committee, the gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Before I comment upon the hearing today, I was asked by the gentleman from Washington, Mr. McDermott, and the gentleman from Maryland, Mr. Cardin, to apologize for their not being here.

They are in an Ethics Committee meeting to hear testimony from Speaker Gingrich as to what he did in his book contract.

It is interesting, I might note, the Speaker had suggested that he was not sure whether that was a murder or suicide for the President's staff, and that is an interesting comment. I am not really sure that the Speaker was harsh to his first wife on her sickbed, but maybe he was. Or I am not sure that he really did something unethical in taking that book contract and whether there was an exchange in title to that, but maybe he did. You are never sure whether somebody is really stealing money or they just appear to be. I am not sure. It is interesting.

Chairman THOMAS. Would the gentleman yield briefly?

Mr. STARK. I yield.

Chairman THOMAS. Obviously, the gentlewoman from Connecticut, Nancy Johnson, is not here, since she chairs the Committee on Standards of Official Conduct.

Mr. STARK. At any rate, I thank you for scheduling this hearing. It is a timely topic for us to explore. Those of us like Mr. Waxman and yourself, Mr. Chairman, remember the prepaid health plan scandals in California in the seventies, and others like ourselves who had to deal with the IMC scandal in Florida in the eighties know that vigilance is required to ensure quality in health plans.

I am troubled, though, Mr. Chairman, by the total lack of witnesses representing beneficiaries. Given the importance of health plan oversight to their health, I would think it appropriate that we hear testimony from those most affected. Beneficiaries surely have a point of view which is as important as hearing once again from the AMA representing doctors with average incomes of $189,000, and all the AMA wants to do is gouge seniors by allowing unlimited extra billing. Might not the seniors, who are going to have to pony up this $14.5 billion to enrich our Nation's physicians, have something to say?

Three recent surveys demonstrate why we need to listen carefully and act aggressively to protect the health of beneficiaries enrolled in private plans. I would like, Mr. Chairman, to ask unanimous consent that the three surveys be made a part of the record.

The Inspector General found significant problems with HMOs screening senior citizens about their health risk, with 43 percent of the Medicare HMO enrollees having been asked at application about specific health problems. That is not right.

The three surveys I mentioned were conducted by the Commonwealth Fund, the Robert Wood Johnson Foundation, and the Inspector General. All uncovered significant problems with managed care. We should not ignore their findings. Whether it is questions about access to services or questions about services for chronically ill patients, managed care plans are rated more poorly than fee-for-service plans. These findings do not suggest that we should stop enrolling beneficiaries in managed care, but they make clear that we must assure strong effective Federal standards, that they are in place to protect the health of beneficiaries who place their trust in us.

I note that many proposals would allow a major role for the States in overseeing health plans, with varying degrees of Federal oversight. In my view and in the view of the majority of experts

surveyed by the GAO, such oversight is absolutely essential by the Federal Government. The capacity of State health insurance regulators, as the GAO testified to in March 1993, is uneven, and the State regulators' records are spotty, at best. That testimony should not be ignored.

Last, Mr. Chairman, I would commend to your attention a bill that Mr. Waxman and I have introduced, the Medicare Beneficiary Protection Amendments of 1995, which all of the Members of the Ways and Means Health Subcommittee have cosponsored and many Members of the Commerce Committee Health Subcommittee have cosponsored. In my view it represents a balanced, fair approach to assuring that beneficiaries who enroll in a private health plan are as well served as if they had stayed in the regular Medicare Program.

Thank you, Mr. Chairman.

[The three surveys were not available at the time of printing.]

Chairman THOMAS. I thank the gentleman.

I just think the record should be clear. Other people can defend themselves, but this Subcommittee has held hearings more than 10 times in which seniors spoke representing various associations. Four of those times, the AARP was on panels. Once again, the AARP was asked to be here. They declined, for whatever reason. So the gentleman needs to know that his side of the aisle asked once again for the AARP to be here and they declined. So the reason seniors are not here is on the basis of their own decision.

The Chair now recognizes the Ranking Member of the Health Subcommittee on Commerce, the gentleman from California, Mr. Waxman.

Mr. WAXMAN. Mr. Chairman, I am pleased to participate in this joint hearing today to examine issues related to the standards for health plans providing coverage in the Medicare Program.

I regret, however, that we are again holding this hearing without having available the Republican plan to change the Medicare Program so that the budget requirements to reduce projected Medicare spending by $270 billion are accomplished.

It was exactly 1 month ago today that Ranking Members Dingell and Gibbons joined Mr. Stark and me and wrote to request that the specific proposal you intend to ask the Subcommittees and Committees to approve be made available. We made that request because we believe it is vital, and indeed the only responsible course for us to take, to provide time for the proposal to be analyzed and understood by the American public that relies on Medicare for health care services, and by the many health care plans and providers who are trying to deliver quality services to our aged and disabled citizens. We do not have such a proposal.

Today we are 1 week away from a recess of this House for the August period. When we return, we will be a mere 14 days from the deadline for reporting the legislation. It is difficult to escape the conclusion that a deliberate effort to keep the American people from knowing what you have in store for the Medicare Program is underway.

What we do have is one document that was obtained by the New York Times which lays out some very troubling proposals to reduce choice in Medicare—or at least leave choice in place only for those with enough income to pay the financial penalties they will face if they try to stay in Medicare as they have known it.

In light of the publicity that document received, we have heard many denials that this represents the Republican thinking. But it remains the only concrete proposal that we have seen, and it is clearly a set of proposals that takes away choice and puts quality at risk.

Without your specific proposal, Mr. Chairman, we can receive testimony on quality issues, but we cannot evaluate fairly the basic issue: Are we going to pay enough to maintain quality care, or have we set a budget target that will result in an increasingly inadequate voucher or defined payment which will ultimately lead to a restriction of services and an erosion of quality.

I would want to make one further point. Maintaining quality in the Medicare Program surely means maintaining protections for Medicare beneficiaries. It means strong Federal regulation and oversight to protect them from plans that discriminate against beneficiaries as they get older and sicker. It means policing plans to protect against risk selection and raising premiums to unaffordable levels. It means aggressive regulation to stop marketing abuses. It means assurance of effective complaint procedures and actions against plans which are not providing quality care to their enrollees.

Unfortunately, so far we have heard a lot about restricting choice and cutting expenditures and about asking Medicare beneficiaries to pay more. But we have heard nothing about the oversight and regulation needed to make this leap into the market anything more than a leap of faith. We have to remember the problem with letting the market work its will, is that sometimes too many people are left out of the will.

So I hope this hearing today will shed some light on these issues. They are not new issues. When I first got started in politics in the seventies, we had a massive push to prepaid plans in California for the MediCal population or Medicaid. What happened, these people were abused. They were taken advantage of. We have seen this over and over again and we are going to hear about it again today.

So I hope this hearing will shed some light on these issues, but I hope this hearing is only the first to address them. Most of all, I hope that the hearing we have the next time will be with a specific plan on the table.

I noted with interest that the Washington Post reported that this view is not only mine, as someone you might want to dismiss because I am a Democrat, but the view of Chairman John Kasich of the Budget Committee who thought that the Republicans ought to let people know what they planned for Medicare, not at the last minute, but with due deliberation and sufficient time for them to review it.

This is also the view expressed in a report from Senator Arlen Specter, a Republican from the State of Pennsylvania, even a Presidential candidate for the Republican nomination. So I hope this is

the first of hearings to address this issue and next time we will have a specific plan on the table.

I want to ask unanimous consent to put in the record a statement of Representative Elizabeth Furse, our colleague on the Commerce Committee. She has introduced, together with the American Diabetes Association, H.R. 1073 and H.R. 1074, to help empower people with diabetes. I think her statement is a very important one and should be part of this record.

Thank you.

Chairman THOMAS. Without objection, the statement will be made a part of the record.

[The prepared statement follows:]

Statement of Rep. Elizabeth Furse
July 27, 1995
before a Joint Meeting of the
Commerce Subcommittee on Health and the Environment
and
Ways and Means Subcommittee on Health

Thank you, Mr. Chairman. Members of the subcommittees, I appreciate your willingness to allow me to make a few remarks today. Diabetes continues to be a serious health problem in America. Diabetes is our fourth leading cause of death, affecting 14 million Americans and costing our nation over $100 billion annually. Contrary to popular belief, insulin is not a cure for diabetes; it only helps those with diabetes properly manage their disease.

If people with diabetes don't have the necessary tools and training to manage their disease, the results are costly, often fatal, complications such as blindness, heart disease, amputations, and stroke. The only way we can help reduce the burden of diabetes, and these costly complications, is to empower people with diabetes to manage their disease. According to the National Diabetes Research Coalition, an organization of leading endocrinologists and other scientists active in diabetes research, a 10% reduction in complications will save a staggering $5 billion.

Earlier this year, together with the American Diabetes Association, I introduced H.R. 1073 and H.R. 1074 to help empower people with diabetes. H.R. 1073 would provide people with diabetes self-management training and H.R. 1074 would ensure coverage of blood testing strips. I am pleased that H.R. 1073 has broad support in Congress, with currently 115 bipartisan cosponsors, including members of both the Commerce and Ways and Means Committees. Representatives Nancy Johnson, Jim McDermott, and John Lewis are currently cosponsors of H.R. 1073, as are Representatives Henry Waxman, Ron Wyden, Sherrod Brown, Gerry Studds, Bart Stupak, Ed Towns, and Bart Gordon. I am also pleased that the American Diabetes Association, the American Dietetic Association, and National Association of Diabetes Educators have testified before the Ways and Means Committee supporting H.R. 1073.

I believe that reforming Medicare is a prime opportunity to help make these important changes to help people with diabetes. Earlier this year, I had a very positive meeting with Speaker Gingrich on these bill, and I think it is fitting to quote from an appearance he made on Good Morning America last year. He said:

> "We don't today pay for training you, as a diabetic, how to take care of yourself. We will pay to put you in the hospital and to amputate your leg when you fail to take care of yourself. But literally, the government bias today is not to pay for the preventive and educational experience that will lower your costs." -- Speaker Gingrich, 7/27/94

Let's follow the Speaker's advice and change the government bias. As this Congress moves to reform Medicare, I urge my colleagues to ensure that people with diabetes have necessary tools -- in both training and equipment -- to manage their disease properly. It will save thousands of lives and potentially billions of health care dollars.

Chairman THOMAS. I will just respond briefly to my friend from California. Since we have not been together on these hearings, I am pleased that this is a joint hearing. We are trying something novel here. We are trying to hear the testimony before we write a plan. The hearing today is on standards for health plans providing coverage in the Medicare Program.

I know the gentleman wishes to refer back to the seventies. In fact, if he did so with the Medicare Trust Fund, he would find that it appeared to be in good shape then. This is the nineties, and we are 7 years away from a bankrupt part A program. I can assure you that when we finish putting a plan together, we will lay it on the table, and I fully anticipate at the time that we lay it on the table, you will lay one on the table, as well.

Mr. WAXMAN. Will the gentleman yield to me?

Chairman THOMAS. Certainly.

Mr. WAXMAN. You do things here differently in Ways and Means. We usually make our statements and then go on to the next Member. Here I guess the Chairman gets to comment on everyone's statement.

Chairman THOMAS. Reclaiming my time, the first witness is Dr. Carlotta Joyner, who is Associate Director for Federal Health Care Delivery Issues, Health, Education and Human Services Division, U.S. General Accounting Office.

Dr. Joyner, any written testimony that you may have will be made a part of the record, and you may proceed to inform us in any way you see fit in the time you have available to you.

Mr. WAXMAN. If the gentlelady would hold off for 1 minute, I would like to be recognized by the Chair.

Chairman THOMAS. The gentleman is recognized.

Mr. WAXMAN. I believe it is important for the American people to see in advance what major changes in Medicare will be and——

Chairman THOMAS. The gentleman said that.

Mr. WAXMAN [continuing]. They ought to have more than 2 weeks' notice, and there ought to be hearings on that plan.

Chairman THOMAS. The gentleman is repeating himself.

Mr. WAXMAN. I emphasize that point. Hopefully, through repetition, minds that are otherwise closed might listen to the message.

Thank you, Mr. Chairman.

Chairman THOMAS. I appreciate the gentleman for his advancement of this hearing.

Dr. Joyner.

**STATEMENT OF CARLOTTA C. JOYNER, ASSOCIATE DIRECTOR FOR FEDERAL HEALTH CARE DELIVERY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY EDWARD STROPKO, ASSISTANT DIRECTOR, AND PETER SCHMIDT, SENIOR EVALUATOR**

Ms. JOYNER. Thank you very much.

I would like first to introduce my two colleagues from GAO who will also be available to answer any questions that you might have, Edward Stropko and Peter Schmidt.

We are very pleased to be here with you today to discuss this important matter of quality health care for Medicare beneficiaries. As

health care cost containment efforts have increased over the past several years, so too has attention to ensuring the quality of that care.

Corporate purchasers of health care want to correct any problems that might result from actions they have taken, such as restricting patients' choice of providers or other actions in the realm of financial incentives that on the one hand might encourage limiting care or, on the other hand, encourage overtreating. These purchasers feel that by evaluating both cost and quality, they can select the plan that provides the best value.

You asked us to discuss today what HCFA, the Health Care Financing Administration, as a very major purchaser is doing and is planning to do to ensure quality of care and make sure that Medicare providers meet, as you said, the very highest standards of health care quality. You asked us also to describe what health care experts believe the important features of a quality assurance system should be.

To develop this information, we relied on our previous reports, our interviews with HCFA officials, and over 30 structured interviews with health care experts, some of whom have testified before your Committees in the past or will again in the future. We selected experts that represent a wide range of perspectives on the matter.

In summary, HCFA has three quality assurance programs. The first of these assesses whether fee-for-service institutional providers meet Medicare conditions of participation. The second assesses similar matters with respect to HMOs, and the third reviews care actually provided in inpatient care settings and in ambulatory surgery to both fee-for-service HMO arrangements.

These programs are carried out through a mixture of Federal and State government and private sector initiatives. For example, HCFA personnel conduct visits to HMOs. State agencies under contract with HCFA conduct these visits within the fee-for-service sector, unless the provider has been accredited by a private organization that HCFA will accept in lieu of its own visits. In addition, reviews of care actually provided are also now done by the private sector, by the peer review organizations comprised of local physicians under contract with HCFA.

Although these programs represent reasonable approaches, we have in the past reported serious problems with their implementation. I might note here also that, except in a recently initiated pilot program, HCFA has no program to assess the care furnished by physicians in their private offices.

The experts we interviewed agreed that the Federal Government, as a purchaser of health care, must continue to play a role in evaluating the quality of care provided to Medicare beneficiaries. They described some features of what they saw as an enhanced Federal quality assurance approach: First, that it would in fact build on existing Federal, State, and private efforts; second, that it would encourage continuous quality improvement; third, that it would obtain multiple kinds of information about providers, especially the adequacy of their basic structures, performance measures, stressing outcome measures and patient satisfaction; and, fourth, that it would make this information available to others.

They also talked about various roles Federal, State, and private entities might take, but really had no consensus on precisely what those would be.

I want to point out that HCFA is beginning to enhance its quality assurance programs in several ways. These include an emphasis on continuous quality improvement, on performance measures and patient satisfaction, and strengthening its collaboration with the private sector through such initiatives as the recently formed Foundation for Accountability. These changes are ones that will take advantage of successful private sector approaches and are consistent with the ideas that we heard from the experts.

The challenge facing HCFA is to make the specific decisions on implementation and to avoid the kind of implementation problems that we have observed in its past efforts.

This concludes my summary statement. I would be glad to answer any questions you might have.

[The prepared statement and attachments follow:]

## STATEMENT OF CARLOTTA C. JOYNER
## ASSOCIATE DIRECTOR FOR FEDERAL HEALTH CARE DELIVERY ISSUES
## U.S. GENERAL ACCOUNTING OFFICE

Messrs. Chairmen and Members of the Subcommittees:

I am pleased to be here today to discuss quality health care for Medicare beneficiaries. As health care cost containment efforts have increased over the past several years, more attention has been paid to ensuring the quality of that care. Corporate purchasers of health care particularly want to identify and correct any problems that might result from restricting patients' choice of providers or from giving providers financial incentives that encourage them to withhold, delay, or limit needed care, or, on the other hand, that encourage them to overtreat. By evaluating both cost and quality, these purchasers believe they can select the plan that provides the best value.

Because of your interest in this subject, you asked us to discuss (1) what the Health Care Financing Administration (HCFA) is doing and plans to do to ensure that Medicare providers furnish quality care in both fee-for-service and managed care delivery systems and (2) experts' views on essential quality assurance components. Our discussion today reflects our past work and an ongoing study for the Subcommittee on Health.[1] To develop this information, we relied on our previous reports, interviews with HCFA program officials, and over 30 structured interviews with experts. We selected these experts to represent a wide range of perspectives: health plans, health care researchers, federal and state agencies, major purchasers of health care, and accrediting agencies. (See app. I for a list of related products and app. II for the experts we interviewed and their affiliations.)

In summary, HCFA has three quality assurance programs. These programs (1) assess whether fee-for-service institutional providers meet certain Medicare conditions of participation; (2) assess whether HMOs meet similar requirements; and (3) review inpatient care and ambulatory surgery furnished under fee-for-service arrangements or by HMO providers. Although these programs represent reasonable approaches, we have reported serious problems with their implementation. Except in a recently initiated pilot program, HCFA has no program that assesses care furnished to Medicare beneficiaries by physicians in their private offices.

Those we interviewed agreed that the federal government, as a purchaser of health care, must continue to play an important role in evaluating the quality of care provided to Medicare beneficiaries. They described an enhanced federal quality assurance strategy as one that (1) builds on existing federal, state, and private efforts; (2) encourages continuous quality improvement; (3) obtains multiple kinds of information about providers--adequacy of basic organizational structures, performance measures, and patient satisfaction--and (4) makes information about providers available to beneficiaries and others in a manner that is useful and understandable. The experts identified enhanced roles that could be played by the federal or state governments and private entities in collecting and evaluating this information, but no consensus emerged on the most appropriate roles.

HCFA is beginning to enhance its quality assurance programs in several ways. These changes include a greater emphasis on continuous quality improvement, performance measurement, and patient satisfaction. Furthermore, HCFA is strengthening its collaboration with the private sector. The changes HCFA is making are ones that will take advantage of successful private sector approaches and are consistent with the ideas expressed by the experts we interviewed. But HCFA faces a challenge in implementing these changes in ways that avoid the kind of implementation problems that have occurred with its past efforts.

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[1]We plan to issue a report to the Subcommittee on Health later this summer that will discuss quality assurance approaches in more detail.

BACKGROUND

Widespread professional interest in monitoring the quality of health care services arose after World War II. Attention increased with passage of federal Medicare legislation in 1965 and, in the early 1970s, the Joint Commission on Accreditation of Healthcare Organizations' mandate that hospitals implement an internal quality assurance program to be accredited.

In 1985, the Department of Health and Human Services (HHS) initiated a nationwide program to expand Medicare beneficiaries' use of HMOs paid on a capitated basis.[2] At that time, federal quality assurance programs were designed to identify HMOs where providers may have withheld or denied treatment because of the financial incentives that result from capitation. In addition, as managed care options became more prevalent, states began to regulate them, and health care purchasers, such as employers, began to develop a greater interest in quality assurance as well.

Quality health care has been difficult for experts to define and measure, but most agree that clinical quality would include

-- appropriateness--providers giving the right care at the right time,
-- technical excellence--furnishing the care in the correct way,
-- accessibility--patients being able to obtain care when needed, and
-- acceptability--patients being satisfied with the care.

These attributes would be measured using indicators that represent (1) structure of care--resources and organizational arrangements in place to deliver care; (2) process of care--physician and other provider activities carried out to deliver the care; and (3) outcomes of care--the results of physician and provider activities. Survey, certification, and accreditation activities generally look at structure measures; performance measurement systems focus on process and outcome measures.

Ensuring quality of care involves reaching consensus about standards and developing reliable and valid structure, process, and outcome measures. Then approaches must be developed to make it more likely that health care will be furnished in ways that will meet the standards. Approaches to ensuring quality have changed in recent years. Under the more traditional quality assurance approach, reviewers focus on a search for individual practitioners or "bad apples" who do not meet minimal acceptable standards of care. But this approach has shortcomings: it creates an adversarial relationship between the reviewers and those being reviewed, and it targets only those providing substandard care. Little attention is paid to those who may be providing care that is better than substandard but less than excellent. The alternative approach, continuous quality improvement, strives to make everyone's performance better, regardless of prior performance. At the same time, this approach acknowledges the importance of taking action, if necessary, against providers with consistently unacceptable performance. Although most health care providers and experts support this new approach, implementing such a dramatic change will take time.

In the private sector, large corporate purchasers of health care use a variety of tools to determine the health care providers with which they will contract. As a baseline, they look for individual providers who are licensed by the state or who are certified by their respective organizations, if state licensure is

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[2]Capitation requires an individual provider or managed care plan to furnish all necessary medical care in return for a predetermined monthly payment for each beneficiary enrolled.

organization. But these structural measures--licensure, certification, and accreditation--have not proven to be fail-safe mechanisms for ensuring quality. As a result, the private sector has taken the lead in developing ways to compare providers using measures of performance, including the results of care provided and employees' satisfaction with their care.

## HCFA'S CURRENT QUALITY ASSURANCE STRATEGIES

HCFA has three activities directed specifically toward ensuring that clinical quality standards are met.[3] The oldest of these, the Medicare Provider Certification Program, has existed since Medicare's inception in 1965. It targets fee-for-service institutional providers of health care. A second certification program, the Federal Qualification Program for HMOs, determines whether HMOs meet similar preestablished standards. The third, the Medicare Peer Review Organization (PRO) Program has existed in some form since 1972. PROs review care furnished in hospitals and HMOs, although they are not precluded from reviewing care provided in other settings.

### The Medicare Provider Certification Program

HCFA's fee-for-service provider certification program is oriented toward institutional providers, such as hospitals, skilled nursing facilities, and home health agencies. With respect to individual providers, such as physicians, HCFA accepts a valid state license as a sufficient basis for direct Medicare reimbursement.

Medicare law requires that if institutional providers of care are to receive direct fee-for-service Medicare reimbursement, they must meet certain physical and organizational conditions of participation. A full-service community hospital, for example, must meet 20 such conditions. These conditions relate to such matters as the hospital's governing body, physical plant, clinical and emergency services, nursing service, and food service. Each of these conditions of participation has multiple standards, most of which must be met if the institution is to comply with the condition.

Conditions of participation identify minimal conditions thought necessary for quality to occur. They relate almost exclusively to structural measures of quality. Furthermore, surveyors checking for compliance only determine whether the institution has established organizational policies and procedures to meet the conditions of participation. Little attention is paid to how well those policies and procedures are adhered to or what the results are.[4]

HCFA contracts with state agencies to perform certification surveys for most types of institutional providers. These agencies periodically (usually annually) send survey teams to the institutions to check compliance. If the team finds that the institution is not in compliance with one or more standards, it will ask for a corrective action plan. For hospitals, home health

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[3]In testimony before the Ways and Means Subcommittee on Health (Mar. 21, 1995), HCFA's Administrator also listed other quality assurance and improvement activities: provisions for beneficiary education; studies in state-of-the-art quality assessment; elimination of fraud and abuse, which are detrimental to quality; and use of clinical practice guidelines.

[4]The Joint Commission is developing a measurement system designed to measure outcomes. This system is intended to be used in conjunction with its current accreditation program.

agencies, and clinical laboratories,[5] HCFA deems the accreditation of designated private accrediting organizations to be adequate assurance that a provider meets its conditions of participation.[6] In deciding whether to accept accreditation by a private third party as a substitute for certification by a state agency under contract with HCFA, HCFA looks at the accrediting agency's survey procedures and compares its standards with HCFA's conditions of participation. Those standards must be at least as stringent as HCFA's conditions.[7] (App. III shows the organizations whose accreditation is deemed equivalent to certification by HCFA; it also lists other organizations that accredit institutional health care providers or units within providers.) State agencies do validation surveys on a small proportion of those institutions whose accreditation is accepted for Medicare certification purposes.

For institutions surveyed directly by state agencies, HCFA personnel perform validation surveys on a small proportion of the institutions. HCFA personnel also survey state-owned institutional providers and clinical labs that are not approved by a Medicare-designated accrediting body.[8]

If problems noted as a result of any of these reviews remain uncorrected, or are of such severity as to seriously endanger beneficiaries, the institution's certification to receive Medicare reimbursements may be revoked. However, in our previous review of this program, we found that HCFA's application of termination procedures casts some doubt on its willingness to terminate any but the worst hospitals from the Medicare program.[9]

The Medicare HMO Qualification Process

HMOs that wish to serve Medicare beneficiaries must have risk or cost contracts with the Medicare program.[10] To qualify for such contracts, HMOs must meet both the requirements of title 13 of the Public Health Service Act relating to federal qualification of HMOs and the requirements of the Medicare statute. As with fee-for-service providers approved under the Medicare Provider Certification Program, these requirements are primarily structural. They require, for example, that the HMO have an adequate governing body, that it have utilization review and quality assurance systems, and that it have an adequate grievance system.

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[5]HCFA certifies clinical laboratories under the Clinical Laboratories Improvement Act (CLIA), rather than under the Medicare program.

[6]HCFA is considering extending deeming authority to private organizations that accredit ambulatory surgical centers.

[7]Procedures HCFA examines include survey procedures, qualification requirements for surveyors, surveyor training programs, procedures for notifying the surveyed entities of survey results, and time frames for conducting follow-up visits if deficiencies are found.

[8]HCFA exempts clinical laboratories in Washington State from inspection because of state licensure requirements that are at least as strict as those under CLIA. A HCFA official told us that a regulation that will exempt labs in two other states--New York and Oregon--is awaiting publication in the Federal Register.

[9]Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate (GAO/HRD-91-54, Sept. 1991).

[10]An HMO that has a risk contract with HCFA is paid a fixed amount for each enrolled beneficiary based on the average Medicare costs for all beneficiaries in the HMO's service area. An HMO that has a cost contract is paid by HCFA a predetermined monthly amount per beneficiary on the basis of a total estimated budget.

HCFA personnel visit contracting HMOs at least once every 2 years to ensure that they are complying with title 13 and Medicare requirements. If an HMO is not in compliance, HCFA may terminate its contract or, in specific circumstances, require it to suspend enrollment. At this time, HCFA does not accept accreditation from any agency as evidence that an HMO meets federal standards.

We have been critical of HCFA for failing to aggressively enforce its quality assurance standards in this process. We have reported on these matters in the past and testified before the Subcommittee on Health, Committee on Ways and Means, earlier this year.[11] In the last 10 years, for example, HCFA has repeatedly found quality assurance problems in certain Florida HMOs. The most recent quality violations included incorrect diagnoses, treatments delayed or withheld, and test results not acted on. One of the HMOs continued to enroll over 100,000 Medicare beneficiaries during a period of noncompliance without any HCFA intervention.

The Medicare Peer Review Organization Program

The PRO program has focused mainly on ensuring that Medicare beneficiaries received good quality of care in fee-for-service inpatient hospital and ambulatory surgical settings.[12] The program's primary methodology has been to review individual medical records, with a focus on process, to make a determination about the quality of care furnished a beneficiary. In addition, there has been a secondary focus on outcomes through focused case review of adverse events such as deaths and hospital readmissions within 15 days of a discharge.

Beginning in 1987, the Congress mandated that the PRO review be expanded to include the quality of care provided by Medicare risk HMOs. In conducting HMO reviews, PROs evaluate the medical records of both ambulatory and inpatient care for a sample of beneficiaries. In a previous report, we made several recommendations to HCFA regarding ways to strengthen the PRO review of risk HMOs.[13] For example, we urged HCFA to incorporate the results of PRO efforts into HCFA's compliance monitoring process.

Although PROs have the authority to review fee-for-service ambulatory care, HCFA has been reluctant to venture into this area. At present, except for ambulatory surgical procedures, the only fee-for-service ambulatory review performed is a pilot project recently begun in three states. In this project PROs and 100 volunteer physicians in each state are cooperating to improve the quality of care provided to diabetics.

Concurrently, PROs in five other states are working cooperatively with 23 HMOs on a similar project. Both the fee-for-service and HMO initiatives will be based on collecting information from medical records about 22 specific performance measures such as the results of important laboratory tests.

HCFA PLANS FOR THE FUTURE

HCFA officials discussed with us several initiatives intended to improve HCFA's quality assurance approach. The initiatives are similar to the kinds of changes occurring in the private sector and in some cases include a closer collaboration with the private

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[11]Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

[12]Before the 1984 implementation of Medicare Prospective Payment for Hospitals, federal oversight concentrated on utilization of hospital services rather than the quality of those services.

[13]Medicare: PRO Review Does Not Ensure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

sector. HCFA's initiatives include increasing the emphasis on continuous quality improvement, developing performance measures, and implementing a more in-depth survey of beneficiaries' satisfaction with HMOs.

HCFA is presently reengineering the entire PRO program to incorporate continuous quality improvement concepts. It found that the old model of review, which focused on individual aberrant cases, was confrontational, unpopular with the physician community, and of uncertain effectiveness. It is restructuring the PRO program to emphasize cooperative projects with providers designed to improve the overall quality of care beneficiaries receive. These projects, which have existed to a limited extent, will increasingly become the main focus of the program over the next 2 years.

HCFA recently announced it was joining a group of large corporate purchasers of health care to form a new organization called the Foundation for Accountability, or FAcct. Among the many goals of this organization are compiling and reviewing the most promising performance measures available on health outcomes and health plan performance. Because this group represents over 80 million insured persons, HCFA and the other FAcct members believe that health plans will adopt their measures and supply the results to them, other purchasers, and individual consumers. According to a HCFA program official, joining in these efforts will help to eliminate duplication of quality assurance efforts and increase the likelihood that managed care organizations will meet purchasers' needs.

Currently, HCFA's Office of the Actuary annually surveys some 12,000 beneficiaries, treated predominantly under fee-for-service arrangements, about their health status, access to care, and satisfaction with the care they receive. To get detailed patient satisfaction data on beneficiaries enrolled in managed care plans, HCFA's Office of Managed Care is considering an additional separate survey.

## COMPONENTS OF AN ENHANCED QUALITY ASSURANCE APPROACH

Many of the experts we interviewed believed that the federal government should continue to play a role in ensuring that Medicare beneficiaries receive quality care regardless of whether that care is provided in an HMO, preferred provider organization (PPO), or fee-for-service setting.[14] They cited the need for information such as (1) performance measures, (2) patient satisfaction surveys, and (3) assurance that basic structural standards have been met. Because each type of information has strengths and weaknesses, the experts recognize that no one technique can be relied upon as the sole determinant of whether an organization provides quality care. But they believed that all programs should foster continuous quality improvement efforts of providers. Furthermore, the experts believed that the strategies should build on existing federal, state, and private efforts.

### Information to Measure Quality

Many experts said that performance measures, particularly those that reflect the outcomes of care, should be used to evaluate quality of care. Furthermore, attention must be given to collecting information about chronic conditions and other unique needs of the Medicare population. When information is gathered, it should be shared with beneficiaries to assist them in their health care purchasing decisions. Experts believed that performance

[14]Our interviews were structured so that we covered the same questions with each person, but because we used primarily open-ended questions some issues were not discussed by each expert.

measurement information could be collected by health plans or providers from their administrative databases or by sampling medical records. However, those we interviewed stressed that PROs or another independent third party would need to verify the accuracy of the data.

The importance of having standardized measures was also frequently cited. Some experts suggested that a national board, composed of public and private health care professionals representing regulators, providers, and purchasers, could be convened to establish a set of uniform measures. However, all agreed that, regardless of who performs the task, any effort to develop performance measures must be a collaborative one with "buy-in" from the provider community.

Most experts also recommended that patient satisfaction surveys be used to evaluate health care quality. Measuring patients' perceptions may include asking them about their satisfaction with the care furnished, their health status, and efforts they make to enhance their health. One expert said that patient survey results can be used to provide information to the consumer or purchaser, to guide a provider in its quality improvement efforts, and to make external comparisons between providers.

As with performance measures, experts stated that consumers like patient satisfaction information. Furthermore, patient satisfaction surveys are already commonly used by health plans and providers. But these surveys also have limitations. They may not produce reliable and valid data, and survey questions and sampling techniques have not been standardized. Other limitations include (1) the difficulty of reaching minorities and others with special needs, (2) the high cost of telephone surveys, and (3) the relative ease of introducing bias into the questionnaire.

Many of the experts said that health care organizations should continue to meet basic structural requirements for participation in the Medicare program. These requirements could be confirmed through a certification or accreditation process. When asked who should make the certification or accreditation visits, experts' opinions were evenly divided among HCFA, states, or another third party. Currently, HMOs and PPOs can seek voluntary accreditation from a third-party accrediting organization, such as the National Committee on Quality Assurance (NCQA) or the Joint Commission. One expert suggested that managed care organizations be given incentives to seek accreditation. For example, an accredited organization might be exempt from a HCFA site visit or perhaps be required to report a lesser amount of performance measurement data.

Some of the experts we interviewed raised questions about the basic concept of voluntary accreditation by a private third party. For example, one expert noted the inherent conflict of interest when an accrediting organization's revenues come from those they are accrediting, as is usually the case. Another noted that it is rare for a plan seeking accreditation not to receive it. However, this individual acknowledged that because accreditation is voluntary, only those who believe they will pass an accreditation survey will seek it. Another expert pointed out that it takes time to develop the systems necessary to be accredited by some organizations. New plans might not have those systems developed initially.

Continuous Quality Improvement

Experts consistently stated that a commitment to continuous quality improvement must be made by regulators, providers, and plans regardless of the quality assurance system implemented. Many managed care organizations implement their own internal quality assurance programs to help evaluate the care they are providing and to identify and correct any problems. Experts also recognized the

value and importance of external oversight programs that are designed to ensure that providers are continually assessing and improving their delivery of care. Such oversight programs are an important tool to identify previously undetected problems, to provide management with constructive feedback, and to assist the providers and plans in improving their overall delivery of health services.

Build on Existing Strategies

Federal and state governments and the private sector have already undertaken a number of initiatives to obtain data about the quality of care. Building upon these efforts was viewed as desirable and beneficial. As discussed earlier, HCFA presently requires HMOs that participate in the Medicare program to have processes in place to identify and resolve quality assurance problems, and some state legislatures have imposed quality standards on HMOs operating in their states. Additionally, the National Association of Insurance Commissioners is discussing the feasibility of developing a model uniform licensing act for all types of health insurers which will include requirements for quality assurance. In the private sector, NCQA and others have developed performance measures. Furthermore, NCQA, the Joint Commission, and others have established quality standards that must be met by any HMOs or PPOs that seek accreditation. And now many employers are requiring managed care plans to gain accreditation before contracting with them for health care services.

CONCLUDING OBSERVATIONS

The federal government, as a prudent purchaser, continues to play an important role in ensuring that Medicare providers meet the highest standards of quality in health care. HCFA has quality assurance programs with that goal, although we have identified problems in their implementation. The enhancements HCFA is making to its quality assurance approach are consistent with the direction in which the private sector is moving and with the consensus of the health care experts we interviewed. The challenge facing HCFA is to make the specific decisions about how these changes will be implemented, confirm that they are effectively implemented, and resolve the relative roles of federal and state governments and the private sector.

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Messrs. Chairmen, this concludes my formal remarks. I will be happy to answer any questions from you and other members of the Subcommittees.

For more information on this testimony, please call Sandra K. Isaacson, Assistant Director, at (202) 512-7174. Other major contributors included James A. Carlan, Jean Chase, Debra J. Carr, Nancy Donovan, Peter E. Schmidt, and Darrell Rasmussen.

RELATED GAO PRODUCTS

Community Health Centers: Challenges in Transitioning to Prepaid Managed Care (GAO/HEHS-95-138, May 4, 1995). Testimony on the same topic (GAO/T-HEHS-95-143, May 4, 1995).

Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

Health Care Reform: "Report Cards" Are Useful but Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

Home Health Care: HCFA Properly Evaluated JCAHO's Ability to Survey Home Health Agencies (GAO/HRD-93-33, Oct. 26, 1992).

Home Health Care: HCFA Evaluation of Community Health Accreditation Program Inadequate (GAO/HRD-92-93, Apr. 20, 1992).

Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate (GAO/HRD-91-54, Sept. 5, 1991).

Medicare: PRO Review Does Not Ensure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, Mar. 8, 1985).

EXPERTS INTERVIEWED

American Association of Preferred Provider Organizations
Lisa Sprague, Director of Legislative Affairs

Gordon Wheeler, President and Chief Operating Officer

American Association of Retired Persons (AARP)
Mary Ellen Bliss, Regulatory Associate, Federal Affairs Department

Joyce Dubow, Senior Analyst, Public Policy Institute

Mary Jo Gibson, Senior Analyst, Public Policy Institute

Alan Kaplan, Consultant to AARP

American Group Practice Association
Julie A. Sanderson-Austin, Director, Quality Management and Research

American Hospital Association
Karen A. Milgate, Associate Director, Policy Development

Ellen A. Pryga, Director, Health Policy

California Consolidated Edison
Pam Kroll, Plan Manager, Health Care Plans

Suzanne Mercure, Benefits Administration Manager, Health Care Plans

Colorado Hospital Association
Larry H. Wall, President

Consumers First
Clark Kerr, President

Department of Veterans Affairs
Dr. Galen L. Barbour, Associate Chief Medical Director for Quality Management, Office of Quality Management

M. Scott Beck, Director, Office of Planning and Evaluation, Office of Quality Management

Debby Walder, Director, Office of Risk Management, Office of Quality Management

Federation of American Health Care Systems
Tom Scully, President and Chief Executive Officer

Good Samaritan Health System
Molly J. Coye, Senior Vice President, Clinical Operation

Group Health Association of America
Kelli Back, Senior Policy Associate, Government Affairs

Carmella Bocchino, Director of Medical Affairs

Candy Schaller, Director of Policy, Government Affairs

Julie Goon, Director of Legislative Affairs

Group Health of Puget Sound
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Harvard School of Public Health
Heather Palmer, Director, Center for Quality of Care Research and Education

Health Care Financing Administration
Gary Bailey, Team Leader, Beneficiary Access and Education, Office of Managed Care

Paul Elstein, Health Insurance Specialist, Office of Managed Care

Dr. Steven Jencks, Clinical Advisor to the Bureau Director, Health Standards and Quality Bureau

Tracy Jensen, Policy and Program Improvement, Office of Managed Care, Health Care Financing Administration

Jean D. LeMasurier, Director, Policy and Program Improvement, Office of Managed Care

Health Pages Magazine
Carol Cronin, Senior Vice President

Henry Ford Health Institute
Dr. David Nerenz, Director for Center of Health System Studies

Jackson Hole Group
Dr. Sarah Purdy, Health Policy Analyst

Jefferson Medical College
Dr. Leona Markson, Associate Director, Clinical Outcomes Research

Dr. David Nash, Director, Director of Health Policy and Clinical Outcomes

John Deere Health Care, Inc.
Dick Van Bell, President

Geri Zimmerman, Director of Quality Management Programs

Joint Commission on Accreditation of Healthcare Organizations
Dr. Paul M. Schyve, Senior Vice President

Margaret VanAmringe, Associate Director, Government Relations

Midwest Business Group on Health
James D. Mortimer, President

National Capitol Preferred Provider Organization
Dr. Robert Berenson, Medical Advisor

National Council on Quality Assurance
Steve Lamb, Director of Government Relations

Margaret O'Kane, President

Park Nicollet Medical Foundation
Dr. Jinnet Fowles, Vice President, Research and Development

Physician Payment Review Commission
David Colby, Principal Policy Analyst

Prudential Center for Health Research
Dr. William Roper

The RAND Corporation
Dr. Elizabeth A. McGlynn, Department of Social Policy

State of Florida
Randy Mutter, Administrator, Research and Analysis Section, Agency for Health Care Administration

State of Michigan
Janet Olszewski, Chief Division of Managed Care, Michigan Department of Public Health

UNIVA Health Network
Dr. William Jesse, President and Chief Executive Officer

Utilization Review and Accreditation Commission
Randall H. Madry, Executive Director

Washington Business Group on Health
Sally Coberly, Director

Wisconsin Peer Review Organization
Dr. Jay A. Gold, Principal Clinical Coordinator

ACCREDITING ORGANIZATIONS

Table I.1: Organizations Whose Accreditation HCFA Deems to Be Adequate Assurance That Providers Meet HCFA Conditions of Participation

| Type of provider | Accrediting organization |
|---|---|
| Hospitals | Joint Commission on Accreditation of Healthcare Organizations<br>American Osteopathic Association |
| Home health agencies | Joint Commission on Accreditation of Healthcare Organizations<br>Community Health Accreditation Program |
| Laboratories under the Clinical Laboratories Improvement Act | Joint Commission on Accreditation of Healthcare Organizations<br>College of American Pathologists<br>American Society for Histocompatability and Immunogenetics<br>American Association of Blood Banks (pending)<br>American Osteopathic Association (pending) |
| Ambulatory surgical centers | Status awaiting final publication and approval of Federal Register notice |

Table I.2: Organizations That Accredit Institutional Health Care Providers or Units Within Providers

| Accrediting organization | Type of provider accredited |
|---|---|
| Joint Commission on Accreditation of Healthcare Organizations | Hospitals, skilled nursing facilities, home health agencies, health networks, and others |
| American Osteopathic Association | Hospitals, laboratories |
| National Committee on Quality Assurance | Managed care plans |
| Commission on Accreditation of Rehabilitation Facilities | Rehabilitation facilities |
| Commission on Office Laboratory Accreditation | Physician office laboratories |
| College of American Pathologists | Laboratories |
| American Association of Ambulatory Health Care | Ambulatory health centers, ambulatory surgical centers |
| American Society of Histocompatibility and Immunology | Laboratories performing tissue-typing and related tests |
| American College of Surgeons | Trauma systems |
| American Speech and Hearing Association | Speech and hearing programs |
| Commission on Accreditation of Free Standing Birthing Centers | Free standing birthing centers |
| National Commission on Correctional Health Care | Health units in correctional facilities |
| American Association of Blood Banks | Laboratories |
| Utilization Review Accreditation Commission | Free standing utilization review programs and utilization review programs in HMOs and PPOs |
| American College of Radiology | Diagnostic and therapeutic radiology units in all settings |
| Community Health Accreditation Program | Home health agencies |
| American Accreditation Program, Inc. | PPOs |

Chairman THOMAS. Thank you very much, Dr. Joyner.

Does the gentleman from Florida wish to inquire?

Chairman BILIRAKIS. I would, Mr. Chairman.

Dr. Joyner, this is one of those times when we wish that the witness had more than 5 minutes. Should HCFA in your opinion accept accreditation by private organizations such as NCQA, the National Committee on Quality Assurance, as sufficient?

Ms. JOYNER. You are saying to do with the HMOs what it now does, for example, with hospitals and home health care and other entities in that respect?

Chairman BILIRAKIS. Yes, and considering it is a private organization. In your opinion, do you think that they should accept their accreditation or is their opinion sufficient?

Ms. JOYNER. What we have done in the past, as you may know, is we have looked at HCFA's process in deciding whether in the case of individual institutions it would accept Joint Commission accreditation or other accrediting organizations' decisions. I think our view would be that such a decision would be more of a policy matter rather than one for GAO to decide. If they choose to do that, we would be glad to do whatever kind of oversight on your behalf that might be useful to see that HCFA follows the procedures they set out for making that determination.

Chairman BILIRAKIS. But you would not hazard an opinion in that regard?

Ms. JOYNER. I think our view would be that that decision—these are difficult and complex decisions as to what actions should be done directly by the Federal Government, by the private sector, by the States—that those decisions are more policy matters to be decided by the administration and by Congress.

Chairman BILIRAKIS. In your opinion, do you think that their quality standards, meaning the NCQA's quality standards, are higher than those utilized by HCFA? Would you have an opinion in that regard?

Ms. JOYNER. We have not done a direct comparison of that. I know that some groups have. I think some of the people that we interviewed felt that the NCQA standards were higher than the standards being used by HCFA. That is something that I could not speak to directly.

I know that HCFA commissioned a study that was just released this last spring that provided a crosswalk amongst various sets of standards, both in NCQA, I believe, and some Joint Commission standards and its own standards and several States, and I think that kind of analysis is the one that certainly would help provide an informed basis for making a judgment like that.

Chairman BILIRAKIS. We depend upon GAO so very much. Do you have any view of the quality of care that Medicare beneficiaries in the traditional fee-for-service have received, are receiving, versus those enrolled in managed care HMOs and other managed care type plans?

Ms. JOYNER. I do not believe GAO itself has done that kind of direct analysis. What we have looked at is how well HCFA has carried out its responsibilities in setting standards and in enforcing them, and we have identified problems primarily with their taking action where they have found problems.

We have identified problems both in fee-for-service and HMOs. HCFA did not take action against a hospital, regardless of the extent to which it was not meeting HCFA standards. We have certainly identified problems with HMOs also where problems exist for a long time after HCFA finds that the HMO is not up to the standards. We certainly would not be in a position to say in general whether people get better or worse care in fee-for-service or managed care.

Chairman BILIRAKIS. How well has HCFA been doing their job, in your opinion, if you have one, regarding services provided by physicians in their offices?

Ms. JOYNER. As I said, HCFA has relied primarily on other ways to ensure that physicians are monitored. First, HCFA relies on State licensing activities. Also, when a physician sends a patient to a hospital, then that care gets monitored through the oversight of the hospital. HCFA's activity has been of that nature, rather than direct oversight of physicians in their own offices.

Chairman BILIRAKIS. To sort of finish up, in general, am I to assume from your remarks that you have not really analyzed the overall HCFA review mechanisms and analyzed the NCQA's quality standards on a routine type basis? What have you done when problems have taken place?

Ms. JOYNER. Are you asking what has GAO done?

Chairman BILIRAKIS. Yes.

Ms. JOYNER. We have not done this kind of analysis of the standards. What we have done, as you know primarily as requested by the Congress, rather than at our own initiative, we have looked at how well HCFA is carrying out its responsibilities. That is where we came up with our observations that I made about the problems that we have identified and made recommendations about in the past on implementation and taking action against providers.

Chairman BILIRAKIS. My time is expired. Thank you, Dr. Joyner.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The Chair wishes to acknowledge the arrival of the Ranking Member of the full Committee on Commerce, the gentleman from Michigan, Mr. Dingell.

Does the gentleman from California, Mr. Stark, wish to inquire?

Mr. STARK. Dr. Joyner, thank you. I am concerned about a proper balance between State and Federal issues and I guess a proper balance between the regulators and the legislators. I just want to suggest a problem in our own State of California.

In California, for example, HMOs are regulated by the Department of Corporations. Traditional insurance is regulated by the Department of Insurance, which I might point out in California these people can be of two different or conflicting political parties because of the structure of our elective process. The Department of Health has the responsibility for general quality of care. So you have three independent and differently directed agencies, each of which has some regulatory authority over a variety of health plans. I am sure the same exists in other States, but I am not that familiar with them.

Would it not be far preferable to have a standard—I do not suppose it makes a lot of difference which department regulates—so

that we know and patients and beneficiaries know that there will be a regulatory authority to whom they can complain or inquire? Would this seem to you from the results of your study to be a desirable feature that we ought to have for any managed care under Medicare?

Ms. JOYNER. I certainly would not want to presume to tell the State of California how to organize its governmental entities. But we did hear from the people that we interviewed a concern about multiple standards. What I pointed out is that, at least with respect to Medicare, there are the Medicare conditions of participation established by HCFA which are uniform throughout the country.

So if we wanted to stay within the realm of the Federal sector, some of the experts we interview saw one Federal role as setting uniform standards, even though it could, should, and would by necessity through the public rulemaking process involve participation of a variety of people. That was sometimes described to us as a Federal role, rather than leaving standard setting up to each State. You were speaking to within the State, but what we heard more was across States.

Mr. STARK. I am just saying that with a variety of managed care plans which are not really defined now, you could have a variety of regulators in each State administering them, and it would seem to me that is somewhat confusing, if not downright inefficient. I am just suggesting that States certainly could choose whom they want to be the regulator. But it would seem to me that if we have Medicare plans and we have a set of standards, that it would be simpler to have them regulated similarly in each State.

I want to raise another issue. I will refer some of the witnesses to some correspondence from Secure Horizons by Pacific Care, a for-profit IPA/HMO in California, some of their marketing material, and a letter that they addressed to the Health Insurance Counseling Advocacy Program.

For the purpose of the question here, one of their statements is that, in accordance with California health and safety code section 1370, the results of their quality assurance reviews are kept confidential.

Now, I have heard a lot about suggesting that beneficiaries ought to be able to choose based on quality. If you are going to keep the reviews confidential, it is a little puzzling to me how the beneficiaries are going to find out who has quality care and who does not. What is the Federal position? Do our rules conflict with that, or are there any standards now for making available quality reviews to potential beneficiaries, and should there be?

Ms. JOYNER. One of the things that I referred to when testifying about the direction that HCFA is going with the enhancing of their quality assurance procedures gets to the issue of providing information to beneficiaries so that they can choose among the plans. This is something that HCFA has expressed a commitment to, getting information out to beneficiaries and identifying valid, reliable performance measures that would be then comparable across various plans and to make that information available.

Mr. STARK. You cannot do that if the State law requires they be kept confidential, can you?

Ms. JOYNER. I believe that the information they collect through these performance measures could and would be public, and they are working with the private sector in doing that.

Chairman THOMAS. The gentleman's time has expired.

Mr. STARK. Thank you.

Chairman THOMAS. The gentleman from Illinois.

Mr. HASTERT. I thank the Chairman.

I certainly welcome this opportunity to have you before us today.

One of the things that I want to pursue a little bit, you have looked at your review of HCFA at how they set up the standards and how it relates. One of the focuses here in the questioning is that we need to have uniform standards across the country. Is it not apparent that in different areas in different States and different types of populations that sometimes standards need to be a little bit flexible? Have you found that in your inquiry?

Ms. JOYNER. At this point, one of the ways that HCFA does take into consideration to some extent the local difference is in their peer review program. PROs are comprised of local physicians who are doing the review of the records. Furthermore, PROs are setting up cooperative projects where the data suggests that there is a problem with the kinds of practice that is occurring in a certain area.

We know that there is wide variation nationwide in the frequency of certain medical procedures, such as hysterectomies or the kind of treatment that occurs after heart attack. Some people see this as a quality problem rather than a likely response to actual differing in what treatment works best. So I think that is one way that they are both reflecting the local situation and wanting to find the best practice and trying to make that more commonly used, rather than continuing the same questionable practice.

Mr. HASTERT. The focus should not be uniformity, but what works best.

Ms. JOYNER. What works best, exactly.

Mr. HASTERT. So that is really kind of a pragmatic view, is it not?

Ms. JOYNER. In terms of individual medical practices, one would assume that what works best would be fairly standard. Individuals are the same around the country.

Mr. HASTERT. Let us look to the future here a little bit. I know that it is hard to do that if you are working in dealing with testimony from the past. In your view of what you have discussed with HCFA, there will be new plans in the future. One of the questions that we have to look at, especially if we want standards, is should those plans have different quality standards of any kind from those that we have had in the past? I mean if we are going to do business in a different way, possibly should those quality standards be flexible enough so that we can do business in a different way?

Ms. JOYNER. One thing that we heard clearly from the experts that we interviewed, when we asked about the central features of a quality assurance approach and strategy, specifically whether they thought the way the government would go about assuring quality would differ depending on whether it is fee-for-service or different kinds of managed care plans, they uniformly said they did not see why that would differ.

What would differ would be, for example, the kinds of data that might be readily available. A more highly structured managed care plan might be more readily able to provide certain information than, say, a PPO or another type of plan. Fee-for-service has certain kinds of information, the actual encounter data available that others do not, but not in the overall goal or approach. That would be different.

Mr. HASTERT. I do not want to frame your answer, but basically there needs to be enough flexibility in there that you can measure, and the future may have to depend a little bit on market and what people drive to and what they want and what is out there for people to go to. Those standards probably need to be in place, but yet with some flexibility, is that not correct?

Ms. JOYNER. The overall standards they felt could be the same. You would have to have some flexibility in applying them, in that you could not expect an entity that had never had a need to collect certain kinds of data to suddenly have it overnight.

Mr. HASTERT. And that information should be available so people can make intelligent choices?

Ms. JOYNER. That information about measures of quality should definitely be available, because people need that in order to make an informed choice.

Mr. HASTERT. Thank you very much. I yield back the time.

Chairman THOMAS. I thank the gentleman.

The gentleman from California, Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

I want to put this issue in perspective. I authored with others the provision in the Medicare Program that would give Medicare beneficiaries an option, if they chose to, to sign up in an HMO. I think Medicare beneficiaries ought to have more choices, but it ought to be their choice.

I know from my own experience, as well, what can happen if we simply say to people that they go out and sign up in a capitated plan, because some of those plans can be scams. People can be taken advantage of. So we have at the Federal and State levels standards that are required of these plans, to be sure that people are not abused. Some of the standards are to be sure people are not abused, and some of the standards are to give people information so they can shop effectively as best they can. After all, it is not that easy a decision.

We are looking at the biggest change in Medicare in 30 years, a dramatic change in health care policy, when we talk about taking $270 billion out of the program. From what I hear from the Republicans, they want to have a lot more plans available. In fact, they would like people to only belong, if they had their choice, in capitated plans, because then you could seal off the amount of money you spend.

Right now, only 1 percent of the Medicare population has signed up voluntarily in HMOs. That has been their choice. Do you think there is any way possible to maintain the level of quality assurance that we see today for that small number of beneficiaries who are enrolled in managed care plans, if we take this kind of money out of Medicare, even that part of the population that is in HMOs?

I know that is a tough question, but it really is the kind of question we are going to have to ask and have answered, in my view, before we start changing the Medicare process. I know it is a difficult question and that is why the Chairman is so prickly about the fact they do not have their plan to accomplish this result. But can we take $270 billion out and still have quality assurance and standards met?

Ms. JOYNER. I really would not have a basis to answer that question. I do not know what would be changed. I do not know what would be different about the program. Even if I did, I am not sure I could really predict what impact that would have on the quality.

Mr. WAXMAN. Well, you can predict on past experience with 9 percent of the Medicare population signing up in these plans. If we end up with 80 percent suddenly signed up in plans that may or may not exist at the moment and move that rapidly, it is going to be a dramatic change.

You emphasize that one essential component of quality assurance strategy is continuous quality improvement. How can health plans be continuously improved if they are limited to increasing spending on enrollees by no more than 5 percent annually?

Ms. JOYNER. Well, the concept of continuous quality improvement would say that the real focus is on finding out what you are doing, how well it is working, and using that information to feed back into your system and try to improve it.

So, instead of just focusing on finding the pieces of your plan that are not working well or the individual providers who are part of your plan who are not following good practices, you would want to look at the patterns of care over the entire plan and try to move everyone to a better level of performance.

It takes some money to do that, to gather information that people may not have had in the past, the data to look at the patterns of care and to set up the process——

Mr. WAXMAN. But the fact is the plans are going to get less money. The plans are going to get less money to do all the things they are supposed to do, including not just making the assessments, but actually providing the care. Are they going to be able to continually improve under those circumstances?

Ms. JOYNER. They would have to make their own decisions about how to live within a reduced budget. I really could not speak to what impact that would have on continuous quality improvement vis-a-vis continuing to have the same amount of money.

Mr. WAXMAN. They will make their decisions, but we have to monitor it, and right now we have a Federal monitoring. But you think HCFA is doing a better job and we need to have State monitoring, but that is all spotty from State to State. Do you think we ought to have defined roles for the Federal and State governments in this regard?

Ms. JOYNER. I am sorry, I did not hear your last question.

Mr WAXMAN. You think we ought to have defined roles as to what will be monitored by the States and what will be monitored by the Federal Government?

Ms. JOYNER. As it is now, there are differing roles and different activities being carried out. HCFA has made certain decisions, and the Congress in its oversight effort has looked at those and given

them advice when they felt they were making the wrong decision. But we would not have a basis for saying exactly what activities should be carried out by the Federal Government, the State, or the private sector. That is a policy matter for them and Congress to determine.

Chairman THOMAS. The gentleman's time has expired.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Yes, Mr. Chairman. Thank you.

Dr. Joyner, I want to congratulate you on your responses to the questions from the most recent questioner from California. You will notice he started out asking whether quality can be assured with only a 5-percent increase, and then he slyly changed to asking whether quality can be assured if they get a decreased budget—trying to imply that there are going to be cuts in the Medicare Program. Of course, that is not the case under any scenario. We fully intend to increase spending on Medicare every year. There will be an increase for these plans that enroll Medicare beneficiaries. So I congratulate you for not slipping into that dialog.

In your testimony, you mention that the NAIC, the insurance commissioners, is studying the feasibility of developing a model uniform licensing act. Can you elaborate on their efforts? For example, what areas are they reviewing, where are they in the process, and are they looking at all types of delivery vehicles?

Ms. JOYNER. Well, they have had several groups over some time working on these issues. When we last spoke with them, they told us that they are drafting 8 model standards. These are in the areas of provider credentialling, utilization management, quality assurance, and grievance procedures. These four they think they will have ready by the end of this calendar year.

The remaining four are on provider contracting, data reporting, accessibility, and confidentiality, although they may combine some of these. They have had various drafts of these standards and are getting comments on them. They are expecting that by the end of the year they will have approved model standards in four of those areas, and then it will be up to the State to decide the extent to which, as it is with the other NAIC guidelines, they would then take legislative action to adopt them within their States.

Mr. MCCRERY. Is the NAIC looking at developing a model standard for all forms of insurance and delivery vehicles in the health care system?

Ms. JOYNER. They are seeing these standards as being ones that would apply across the board, in fee-for-service and in all types of managed care. That apparently has been a difficult discussion that they have had, as to whether certain managed care arrangements could adequately be addressed in the same guideline, the same standard, and at this point they feel that it can be.

Mr. MCCRERY. Thank you, Dr. Joyner.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Michigan, the Ranking Member of the full Commerce Committee, an ex-officio Member of the Subcommittee, does he wish to inquire?

Mr. DINGELL. Thank you, Mr. Chairman. I appreciate your courtesy.

I have a particular concern and that is if we cut Medicare by $270 billion as has been suggested by my colleagues on the Republican side, does that mean that there will be any room for the traditional freedom of choice plan, or will it all move toward an HMO-type plan for the care of senior citizens receiving benefits under the Medicare Program?

Ms. JOYNER. I would not have any basis to know how that would be done.

Mr. DINGELL. You would not know the answer to that question?

Ms. JOYNER. Excuse me?

Mr. DINGELL. You would not know the answer to that question?

Ms. JOYNER. That is correct. I would not be able to predict how HCFA would decide to allocate the resources, whatever resources it has available for beneficiaries.

Mr. DINGELL. That is a significant cut, is it not, in Medicare benefits?

Ms. JOYNER. I really would not know what adjective to put on it. I think that is more a matter of personal judgment.

Mr. DINGELL. Maybe I ought to put it a different way. Would you call it an insignificant cut in Medicare benefits?

Ms. JOYNER. I would rather not put any adjective on it at all, sir.

Mr. DINGELL. $270 billion is a lot of money.

Ms. JOYNER. That is a lot of money, yes, sir.

Mr. DINGELL. It would pay for a lot of health care benefits?

Ms. JOYNER. Excuse me, I did not hear the question.

Mr. DINGELL. It would pay for a lot of health care benefits?

Ms. JOYNER. Yes, sir, it would.

Mr. DINGELL. If we took $270 billion out of Medicare, what would that leave us in the way of health care benefits?

Ms. JOYNER. I am not sure exactly what the dollar figure would be.

Mr. DINGELL. A lot less health care benefits?

Ms. JOYNER. It would be less, yes, sir.

Mr. DINGELL. Now, would we assume that this would lead us toward a system of HMOs for Medicare recipients?

Ms. JOYNER. You are saying would that be sufficient to meet the needs?

Mr. DINGELL. Yes. In other words, if you take $270 billion out, is that going to put pressure on Medicare to go to HMOs?

Ms. JOYNER. I really would not have a basis for answering that.

Mr. DINGELL. I would be able to assume that it would put pressure on, and certainly that it would not remove pressure to go to HMOs. Is that not right? Because it is going to require cuts in expenditures, is that not right?

Ms. JOYNER. I really would not have a basis for knowing what that would do with respect to more or less managed care.

Mr. DINGELL. Who aside from my Republican colleagues would be able to give me an answer to these questions?

Ms. JOYNER. Excuse me?

Mr. DINGELL. Who aside from my good friends and Republican colleagues would be able to give me answers to these questions?

Ms. JOYNER. You might talk with the people at HCFA on how they would respond to varying levels of resources.

Mr. DINGELL. I think I will have to be doing that. One of the things that sort of tweaked my concerns with being a member of the bar, I got, as did a number of Members around here, letters from the D.C. Bar Association, the Membership Benefits Committee of the District of Columbia Bar, and it involved two things. One was a letter which you see over there, and the other was a pamphlet of which we have reproduced the first copies. Basically, what it says is that managed care—well, first of all, it says that members of the D.C. Bar should contact the bar, and they said this:

> In the rush to cut costs, some health care plans have been steadily restricted to the amount of care your family can receive. In fact, it has gotten to the point where some plans refuse to cover certain procedures, even if your doctor deems them necessary. Unfortunately, that could never happen under a major medical plan like ours.

They go on and they talk about being essentially forced into HMOs. In the brochure that they have put around, they said, "Settle for a managed care plan and you would find yourself on some pretty thin ice." They go on and say, "Watered down medical protection could put your family at risk." These are a pretty smart bunch of people in the D.C. Bar Association, are they not, good lawyers, a lot of lobbyists interested in things like government and government programs, including Medicare.

I wonder if we ought not listen to them on their point with regard to watering down plans. I wonder if maybe the plans that are coming forward from my Republican colleagues are not going to water down Medicare so that it is going to put, as the D.C. Bar Association says, families at risk, or it could put people on thin ice. I guess maybe I will have to ask HCFA, should I not?

Ms. JOYNER. Yes.

Mr. DINGELL. Thank you, Mr. Chairman. You have been very curious.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Texas wish to inquire?

Mr. BARTON. I thank the distinguished Subcommittee Chairman. It is a pleasure to be in this hearing room of the Ways and Means Committee as a Member of the Energy and Commerce Committee. I have never been in a hearing room that had gilded chandeliers and Greek or Roman columns and gilded water pitchers with their names on it. We do not have that over in our Committee, and I am impressed. We do, however, have Members that are just as interested in finding some solutions to the Medicare problem which, if we do not do anything, everyone acknowledges that Medicare is going to go bankrupt.

Today's hearing is focused on quality assurance. In reading the testimony of our first witness, I am a little concerned about what HCFA is and is not doing in that area. In your written testimony, you say:

> Surveyors are checking for compliance only to determine whether the institution has established organizational policies and procedures to meet the conditions of participation. Little attention is paid to how well those policies and procedures are adhered to or to what the results are.

Then it says: "HCFA's application of termination procedures"—and this is with respect to hospitals—"casts some doubt on its willing-

ness to terminate any but the worst hospitals from the Medicare Program."

My first question is do you think that HCFA needs to do more in the enforcement area or in the investigative area about insisting that the quality plans that are in place are actually carried out, and if they are not, that those hospitals and other organizations that HCFA surveys for quality are decertified?

Ms. JOYNER. Absolutely. GAO has spoken to that issue for several years now and our message is still the same. We feel that where a provider is not providing quality care and it is not meeting Medicare requirements, then action should be taken against such a provider.

Mr. BARTON. Do you think that the senior leadership in HCFA has gotten that message? Do you think they realize that as we look at the problem of waste, fraud, and abuse in Medicare, that part of that solution has got to be stricter scrutiny and also enforcement when there is a problem?

Ms. JOYNER. I believe I will let Mr. Stropko speak to that.

Mr. STROPKO. We have been looking at this issue since probably 1984. I personally have been looking at it, and every single year I thought it would get better the next year and it has not.

Mr. BARTON. Mr. Bilirakis and I have been holding some joint hearings in the Energy and Commerce Committee on waste, fraud, and abuse in the Medicare Program, and we are developing as we speak at the staff level a list of proposed remedies to deal with that. But part of it has got to start at the top with the leadership realizing that there is a problem and committing themselves and their senior associates to dealing with it, because we have seen again in our Committee, Chairman Dingell and Chairman Waxman have held hearings in the past and they say the same things every year and they do not do anything. This year we think it is going to be different.

I have one more question, Mr. Chairman, and then I will yield back.

Another witness after you for the private quality assurance organization talks about, as they look at their standards, the NCQA standards. They have a section on members' rights and responsibilities when they are looking at HMOs. It says, "How clearly does the plan inform members about access to services, how to choose a physician or change physicians, and how to make a complaint." I notice that HCFA right now, when they are looking at the HMOs, apparently does not list that as a standard. Do you think that patient information and members' rights and responsibilities should be included in these standards, as we look at the HMOs and PPOs?

Mr. STROPKO. Most certainly.

Mr. BARTON. Mr. Chairman, I am going to yield back. I love your orange light. We do not have that. We just have a red light and a green light. As an industrial engineer, I think that orange light is very useful to moving the hearing along, so I am going to try to get our Committee to adopt that as an improvement.

Thank you.

Chairman THOMAS. I will tell the gentlemen we used to have a stop sign which he might be more familiar with, but we thought the lights were a little more modern.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I am amused that my friend from Michigan is relying upon a letter from the trial lawyers and the D.C. Bar Association for help on Medicare. In my opinion, he is really scraping the bottom of the barrel to buttress his argument. These are the same people that are fighting the American people on tort reform and frivolous lawsuits, and it is amazing that you would have to go to the D.C. Bar Association to try to get help.

I want to thank Dr. Joyner for not giving a political answer to my friend from Michigan, because truly, to remind the people again, $4,800 this year, $6,700 in 2002 is what the spending will be on Medicare; a $1,900 increase.

With that increase and the rapid growth rate that we see with the baby boomers coming also in the year 2012, do you think that HCFA, since it is having a hard time now in keeping up with its enforcement of quality assurance in the risk contracts, will be able to keep up with the significantly expanded program that we have, or are we going to have to look elsewhere to continue to make sure that quality assurance is there?

Ms. JOYNER. I would assume that you could call on HCFA to allocate its resources appropriately if more beneficiaries are in one kind of program than in another. Again, in part that goes back to some questions that were raised earlier. Right now, HCFA does its own reviews for the risk HMOs, unlike relying on private sector accreditation as something that takes some of the burden of direct checking, if you will, on people themselves, and unlike what they do in the fee-for-service with the State involvement. So they are using other models in the fee-for-service and they may or may not wish to consider some of those on the HMO side, on the managed care side.

I think that you are raising a good question about how they respond to a changing world that they are responsible for overseeing in terms of quality.

Did you want to add anything to that?

Mr. STROPKO. The only other thing is there is a sort of funding barrier, administrative funding for that program has gone down over the last 5 years on a per capita basis largely because of the Budget Enforcement Act, of course. There are some amendments that you could make to the act to make it a little easier to provide additional funding to the extent that you think it is warranted by a change in program direction. It is just that within the existing budget constraints it is very hard to do.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Ms. Joyner, I can see how it is difficult to answer some of the questions, when what we are doing is just surmising. We are talking about a phantom plan which will not be before us until probably sometime in late September or mid-September. Our problem is that you will not be invited back and your experts will not be invited back to respond at that time. So based on what we know

today, we are trying to get some feedback from people like yourself to make sure that we have some direction on where we are going.

If in fact we would take about one-third of the Medicare population, let us say 10 million people and put them into HMO's managed care immediately, would your guesstimate be that there would be savings or large savings to the Federal Government and to the program?

Ms. JOYNER. I do not think we would have a basis for estimating what those savings would be.

Mr. STROPKO. Right now, there probably would not be savings largely because the existing formula for developing payment rates in HMOs is widely recognized as flawed. They do not adequately account for the differences in health status between those people who choose to enroll and those who remain in the fee-for-service sector, so something would have to be done with the reimbursement structure.

Mr. KLECZKA. What would that be? Do you have any guesstimates? Using the scenario of 10 million people, what would have to change in the reimbursement to make sure that we can extract at some point in time $270 billion over the next 7 years?

Mr. STROPKO. That is kind of a technical question, but basically you would need some better ways of measuring the health status of those who choose to enroll. They are called risk adjusters, and it is something that has befuddled HCFA and the researchers for the last decade.

Mr. KLECZKA. Do you think the possibility exists that HMOs would cherrypick to make sure that they are not exposing themselves to large risk and that the sickest of the folks would be left back in the old fee-for-service?

Mr. STROPKO. That is the name of the game.

Mr. KLECZKA. So that game could be played unless we prohibit it?

Mr. STROPKO. That is part of marketing in insurance. That is part of the game.

Mr. KLECZKA. So then the savings would not really be realized because the sick people, the big risk, would still be in the program, very possibly still in the fee-for-service?

Mr. STROPKO. Until you have fixed the payment rate problem, you are not likely to realize savings, unless somehow you have a way of dealing administratively and assigning people to HMOs.

Mr. KLECZKA. No, we want to give them choice. We do not want to assign people. What would happen to the people in the program who would stick around in the fee-for-service, if in fact the insurance companies, like they do now, cherrypick off the healthier individuals? If the sickest ones are in the fee-for-service program, what would have to happen in the fee-for-service? Would we have to cut back benefits, raise out-of-pocket costs? What would occur there?

Mr. STROPKO. Costs would increase at a more rapid rate.

Mr. KLECZKA. Again, under the guise of trying to pull out $270 billion, knowing full well the Federal contribution is not going to be increasing, in fact it is going to be decreasing, what would the effect be on the beneficiaries who stayed in the fee-for-service mainly because they do not have a choice?

Mr. STROPKO. That is hard to predict. I think the program would be facing an increasing growth in cost and pressure on the benefits side.

Mr. KLECZKA. We have had Medicare Select on a pilot basis in various States. Has the GAO looked at that at all? I know we are getting a study at the end of the year.

Mr. STROPKO. I do not believe so.

Mr. KLECZKA. Because in my query to HCFA, they indicate that even though there is some increased benefits for the beneficiaries, we find that the Federal Government has not saved much, if any, through the Medicare Select Program, which I would guess is being used as the model for the phantom changes in Medicare which we have not seen yet.

I thank you for your responses.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Texas wish to inquire?

Mr. JOHNSON of Texas. Thank you, Mr. Chairman.

I would just like to remark that the phantom plan out there has as lot of choices and they are all phantom choices, and all of them are less costly than the fee-for-service. Maybe we can resolve it among ourselves when we actually see the results of what people can select when they are given a choice.

I have no more phantom questions, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Pennsylvania wish to inquire? Any phantom speculations?

Mr. GREENWOOD. Thank you, Mr. Chairman.

I am sorry that the Ranking Member of the Commerce Committee Mr. Dingell has left, because I wanted to respond to a question he posed to the panel. His question was: If we have to significantly reduce the rate of growth in the Medicare Program, do we have to move people from fee-for-service into managed care? The panel clearly was not prepared to answer that question.

He asked the panel to whom he could address that question other than the Republicans. My suggestion to Mr. Dingell would be that he go to his staff and say: The President wants to reduce the rate of growth in the Medicare Program by $121 billion over the next 7 years. That is based on the OMB baseline.

If you correct that for the CBO baseline, you add $74 billion and you see that the President wants to reduce the rate of growth in the program by $195 million over 7 years. Then he could turn to his staff and he could do what the Republicans have done. That is, he could bring in experts from all over the country and sit down hour after hour, day after day after day in a very scholarly, conscientious, and diligent fashion and try to determine what the appropriate response would be. I would recommend that to my colleagues on the other side of the aisle. They might try to have some of the creativity that we have.

Mr. WAXMAN. Would the gentleman yield to me?

Mr. GREENWOOD. Briefly.

Mr. WAXMAN. It is interesting to hear that the Republicans are meeting with all these experts. Are these closed-room meetings and are the rest of us invited?

Mr. GREENWOOD. You are invited to participate in the same exercise, as you choose.

Reclaiming my time, I was interested to read in your testimony, Dr. Joyner, that HCFA has joined a new organization called the Foundation for Accountability. I was also interested to read that a number of experts have recommended the formation of a national board composed of public and private health care professionals representing regulators, providers and purchasers, which could be convened to establish a set of uniform measures. Do you see redundancy there? Do you think that this new Foundation for Accountability and the national board would have different functions to perform?

Ms. JOYNER. I might say that our interviews with the experts preceded the announcement of the Foundation for Accountability, so some of them may have known that those ideas were being considered, but it was prior to the time that the Jackson Hole group convened. I think they are both in the same direction.

At this point, we have talked with some people who are part of the foundation group about how they plan to proceed with this, but I do not think they have the specifics worked out yet of exactly how they will move ahead. If we were to go back to the experts again, they might no longer feel the need for something like a national board.

When the experts we interviewed spoke of a national board, it was seen as something like the PPRC or the ProPAC. For example, there could be an advisory board and then people would talk to researchers who worked on this to seek input and really try to pull together all the information about measures such as the pros and cons of different ones. So if we were to go back to them after the foundation has proceeded with its work, they might feel that that was sufficient. I think it is a little early to know for sure.

Mr. GREENWOOD. You noted in your testimony that HCFA's Office of the Actuary annually surveys some 12,000 beneficiaries treated predominantly under fee-for-service arrangements about their health status, and so forth. Has the Office of the Actuary done a similar study exclusively on the Medicare population within managed care?

Ms. JOYNER. No, they have not. The current survey would potentially include people who are in managed care if they happened to be in the sample, but it is not focused on managed care. That is why the Office of Managed Care is considering doing a separate survey to get specific information about satisfaction of beneficiaries in managed care.

Mr. GREENWOOD. I assume that you would encourage them to do that.

Ms. JOYNER. I would certainly encourage that, one way or another, HCFA get that kind of information and ideally that they get it in some form that is comparable for fee-for-service and managed care. That is a question that gets raised, and I think that HCFA has some responsibility to provide some answers.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Iowa wish to inquire?

Mr. GANSKE. Thank you, Mr. Chairman.

Dr. Joyner, I remember when I first decided to run for office, I decided to do a survey. And when I talked to the pollster, he said, What do you want the poll for? I looked at him quizzically and I said, Well, I want to know what my chances are, why did you ask? He said, Well, because we can find out the truth or we can use a poll for other purposes.

Now, part of what we have going on is we have a lot of surveys and polls that are being done and it is hard to get at exactly what the statistical validity is because of the way questions can be asked and the facts are moved around.

We have a lot of data where proponents of managed care say that patients are very happy, and opponents say they are not so happy. How does HCFA get at the validity of patient satisfaction surveys, and should this be done by a totally separate entity, an office of statistics, or something that can review this?

Ms. JOYNER. We have talked with people about this issue, and you have certainly hit on a point that many of them raised: the objectivity and the importance of the wording of the question and a lack of confidence at this point in the results. For example, individual plans will often put out information about how satisfied their patients are, and then you have this competition. Everybody says our people love ours. It is exactly that concern, with each plan developing its own, that the potential for bias is there.

So what we heard was that surveys should be done by a more independent source. So if you were to consider HCFA to be unbiased in what it is trying to get at, and if it were collecting information on beneficiaries in both kinds of plans, then I think the people we talked with would certainly consider that to be more credible than surveys done by an individual plan or by an organization that represents managed care plans. There is always going to be the recognition of the inherent bias, intended or otherwise.

Mr. GANSKE. I think it would be important for us to look, if we are going to be providing choices, at having patients be able to compare apples to apples, and so forth.

Ms. JOYNER. Exactly.

Mr. GANSKE. I imagine that you have thought a great deal about how to make sure that there are some patient protections in wherever we are going, and I am sure managed care will be part of that, and some other options will be, also.

Let me ask you a few specific questions. Do you think that it would be reasonable to ensure a prompt authorization within some time-limited period of time for a patient who is in an emergency room waiting for treatment? Should that be something that is included?

Ms. JOYNER. That that should be an expectation of a quality program, that this authorization come quickly, I would assume so. I do not know how that is dealt with in standards right now.

Mr. GANSKE. I could tell you right now it is a weakness in the Medicare Program. They have a pretty good appeals process, but from the perspective of a beneficiary that feels that they need urgent services and need an emergency room and they are obviously not necessarily in a position to know whether they really do need emergency service, they are not likely to get an answer to the question of whether or not that is covered for 6 or 8 weeks, sometimes

6 or 8 months. They end up being liable for some fairly substantial payments that they do not feel they justifiably should pay. Would you think that it is important to have a prompt and fair appeals process for resolving coverage denial complaints?

Mr. STROPKO. Yes. We have a good process right now, but it is not timely.

Mr. GANSKE. How about a ban on financial incentives on providers which may limit referrals or treatment options?

Mr. STROPKO. Right now, HCFA is responsible for coming up with some guidelines. The statute was 1990, and they still have not come up with guidelines for risk-sharing arrangements. I think that is critically important.

Mr. GANSKE. It looks like my time is finished.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Oklahoma wish to inquire?

Mr. COBURN. Thank you, Mr. Chairman.

Dr. Joyner, thank you so much for being here. One of the things I observed as I have heard the questions asked, do you have studies to show that the only way we improve the quality of care is by spending more dollars?

Ms. JOYNER. We have not done such studies.

Mr. COBURN. So the assumption that we hear made routinely by many is that we in fact cannot improve quality of care unless we spend more money, and that is pretty disturbing to me because that frames the whole debate. That says that the way we are treating and caring for our patients today under the provisions of Medicare is a very efficient, cost-oriented, quality-oriented program, and that the only way we could improve that would be by spending more dollars to offer more services.

In the Medicare system today as you all look at it, are there hurdles that prevent improved quality of care without spending more dollars?

Ms. JOYNER. Mr. Stropko, you touched on one of those a moment ago. I will let him elaborate on that, on the kinds of obstacles to improving within the same amount of money.

Mr. STROPKO. HCFA is almost legislatively prohibited from using a lot of the basic managed care techniques in the fee-for-service sector.

Mr. COBURN. Remember, I am talking about quality of care. I am not talking about reducing dollars. I am talking about improving the quality of care with the same dollars.

Mr. STROPKO. In a sense, that implies to me the ability to manage care a bit, to apply a case management approach that could help you look at both what is necessary and what is cost effective. Right now, there is no mechanism in HCFA to do that. HMOs presumably do that when they are under contract with HCFA, but HCFA cannot apply that strategy to the fee-for-service sector, say, as Blue Cross & Blue Shield could apply through development of preferred provider networks and certain case management programs that they have for diabetics, and so forth.

Mr. COBURN. At the same time, there is not the assumption that we cannot—what I am trying to get to is the baseline is that we have to spend more money to improve quality of care. That is just

not true. We can improve quality of care by spending no additional dollars, if in fact we spend the dollars more wisely, if we allow a large portion of choice with those who are Medicare beneficiaries, but also in the system as it works to supply that need. Is that not true?

Mr. STROPKO. I think there is so much waste in the system right now that it is a pretty good strategy to say that is true. It is very true. It seems to me that with better management of care, you could save a lot of money and also maintain or even enhance quality.

Mr. COBURN. So you would agree with the principle that with a flat number of dollars and given the same number of providers, if we looked at doing it a better way, that we could in fact enhance quality of care with the same dollars?

Mr. STROPKO. Doing it is another matter, but I think theoretically——

Mr. COBURN. So it would follow that if we had a marked increase in the number of dollars over the next few years, that we ought to both be able to take care of an additional number of people and at the same time improve the quality of care, if we say that is what our goal is.

Mr. STROPKO. It is not impossible.

Mr. COBURN. Let me go to one other area. We have seen lots of data and you have heard mention several times fraud and abuse. Give me your feeling. The range is anywhere from 10 percent of the total dollars down to 4 percent, and some people even say 20 percent. If you had to pick a number, a percentage number on Medicare, where would you say pure fraud and then fraud and abuse?

Mr. STROPKO. We have never looked at it that way. We have picked a number for fraud and abuse and the number we have picked is 10 percent, and largely that is a number that we got from talking to a lot of people that are in the claims processing business, both in the private and the public side. That number has been on the street for the last 4 or 5 years, and the numbers have been, just as you said, all around that. I do not think anyone could ever by its very nature define what a precise number is, because it is invisible.

Mr. COBURN. So if we did look at that and we assumed that an average of all the experts that we have heard was around 10 percent, and that if we eliminated 5 percent of that, one-half of that, 50 percent of that, we eliminated that, we would see significant dollars to be able to be put back in for care, would we not?

Mr STROPKO. I think both GAO and the OIG can point to those dollars in our studies. There is a lot of waste out there and a lot of abuse.

Mr. COBURN. So there is significant savings from the elimination of fraud and abuse?

Mr. STROPKO. They are documentable, yes.

Mr. COBURN. Thank you very much.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from Georgia wish to inquire?

Mr. NORWOOD. Thank you, Mr. Chairman.

Dr. Joyner, I am a freshman and would ask that you be very gentle with me. I am trying to figure out how this system works

up here. I have so much admiration for Mr. Dingell, who has done such a fine job for 40 years. I sit here on this panel and I know that we are talking about a Medicare Program that is going to increase its spending by 40 percent, and he keeps telling me, you fool, that is a cut, do you not understand? I really am trying to understand how we can increase our spending in such a considerable manner, and we seem to get a lot of people shaking their heads even out there that, boy, you are really cutting that program.

Help me with some numbers. It is my understanding that over the next 7 years the Medicare Program will spend $1.87 trillion. Tell me, what that would be?

Mr. STROPKO. I cannot do math that quickly in my head. We are talking about $160 billion right now growing at 10 percent a year, and so somebody better than I is going to have to do the calculating.

Mr. NORWOOD. That is not too far wrong, is it?

Mr. STROPKO. I do not know.

Mr. NORWOOD. Who in Washington determines that that is what we are going to spend?

Mr. STROPKO. I think we just sort of look at what we have spent in the past and that is sort of the best——

Mr. NORWOOD. Who is we?

Mr. STROPKO. HCFA.

Mr. NORWOOD. Is it HCFA or is it the 104th Congress who decides it? Who made the estimate that we will spend *x* amount of dollars, that amount Mr. Dingell wants to spend over the next 7 years, HCFA?

Mr. STROPKO. They, ProPAC, those are the numbers that are——

Mr. NORWOOD. So we find that HCFA and Mr. Dingell want to spend *x* amount, the President wants to spend a little less than that, and the 104th Congress is saying we are just going to slow this growth down enough and it will not be the same amount of dollars. Is that how we get to that? Who do we trust? Who do we know who knows how much it will cost?

Mr. STROPKO. I think to a large degree how much it will cost in the future depends on the policies you make this year and in the coming years. I think if you say things are going to continue to go as they are going right now, then you have a fairly good baseline to measure and the 10-percent growth rate is not an unreasonable expectation. Wanting to live with that growth rate and being able to live with that growth rate is quite another matter.

Mr. NORWOOD. I gather that is what my distinguished friend wants to do, just lest it go on like it is going. If we do that, what do you think will happen to the trust fund in 2002?

Mr. STROPKO. That is a for sure. I mean the trustees indicate that we are going to be in big trouble.

Mr. NORWOOD. Do you mean it will be out of money?

Mr. STROPKO. Yes, sir.

Mr. NORWOOD. What about all these people who need health care, senior citizens who want their Medicare Program?

Tell me, Do you have any idea what we spent in Medicare in 1990, $150 billion?

Mr. STROPKO. Less than that.

Mr. NORWOOD. $140 billion? $130 billion?

Mr. STROPKO. Probably.

Mr. NORWOOD. $130 billion, let us just say that is it. Back in 1965, somebody up here decided that they would look out into the future and determine what the Federal Government would be spending in Medicare in 1990. I do not know who it was. I do not guess HCFA was up and going then. Maybe it was Congress. Somebody looked out and said that Medicare was going to cost us $9 billion in 1990. What in hell happened? We must not be very good with our numbers in this town and we are seriously talking about big dollars here, and we do not have a clue what it might cost in 2002. Yet, we have our friends over here saying do it anyway.

That is all, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

Does the gentleman from North Carolina wish to inquire?

Mr. BURR. Thank you, Mr. Chairman.

Welcome, Dr. Joyner. I would like to go straight to the concluding observations that you made in your testimony, and I will read a couple of sentences.

HCFA has quality assurance programs with that goal. Although we have identified problems in their implementation, the enhancement HCFA is making to its quality assurance approach is consistent with the direction in which the private sector is moving and with the consensus of health care experts we interviewed.

Now, I interpreted that to say that HCFA is trying to replicate the successes that have been experienced in the private sector. Would that be a correct interpretation of your conclusion there?

Ms. JOYNER. They are attempting to use some of the techniques. To take as an example, continuous quality improvement has been shown to be helpful not just in the health care industry, but in many other industries, as well, as a way to improve the product or the services that you are delivering. That is the point that we are making.

Mr. BURR. Could I also interpret that "although we have identified problems in their implementation" means that they are not doing as good a job as one would hope?

Ms. JOYNER. In the past, they have not done as good a job as we—and I am sure you—would have hoped in carrying out their program.

Mr. BURR. Since in health care Mr. Norwood very eloquently displayed that we use the past to predict the future, can we expect a different outcome than what we have seen, which is failure?

Ms. JOYNER. Well, that is why we pose it as a challenge facing HCFA and facing the Congress in its oversight of HCFA, to make sure that as it moves in these directions, that it does so effectively.

Mr. BURR. In the private sector plans that you referenced, who determines the quality of care?

Ms. JOYNER. The corporate purchasers that we talked about collect data on the kind of care that is being provided. They often require accreditation.

Mr. BURR. Who do they ultimately answer to about the plans that they choose?

Ms. JOYNER. Well, they ultimately answer to their stockholders and they answer certainly to their employees who are in these plans who expect to receive good care and who, if they do not receive good care, in fact end up costing the company more money.

Mr. BURR. Is it realistic for the Members of the Subcommittees to believe that seniors in this country can make the same quality of care decisions that we see exemplified in the private sector plans?

Ms. JOYNER. That Medicare beneficiaries can make the same choices, make the same decisions, is that what you are saying?

Mr. BURR. The discussion on this Subcommittee now is can we inject some of the private sector successes, the choices of different types of plans, into what has traditionally been a government dominated, government run HCFA administered health care delivery system, not to do away with it. You have identified that in fact they are struggling to meet the private sector accomplishments. My question would be, Can we expect seniors to also respond in a similar fashion that we do people in private sector plans to the quality of care? If the quality of care is not there, seniors will scream, if it is, they will praise the plan.

Ms. JOYNER. They will need information just as people not on Medicare need information about the quality of care. To some extent, individuals—I or you or a Medicare beneficiary—are able to judge the quality of what we are getting. But sometimes we do not know and we need somebody else to help identify the quality of care and give us some report card, give us some consumer reports that we can use so that we know whether we are getting the right care. If so, I would assume that they can make choices.

Mr. BURR. From the standpoint of the GAO, let us consider that down the road we inject into Medicare private sector options, different plans for seniors with the high quality of care that you have made reference to here. Will the current HCFA, the HCFA that your report was about, need to change significantly to compete on both a cost and quality of care standpoint for those people accessing care?

Ms. JOYNER. Yes, it will need to more effectively carry out its quality assurance activities.

Mr. BURR. Thank you, Dr. Joyner.

Mr. Chairman, I yield back the remainder of my time.

Chairman THOMAS. I thank the gentleman.

I want to thank you. Just a couple of questions on a followup, so that people can understand some of the points that were made. I will not go into the dollar amount discussion. Although "cut" is continually used, that is not what we are talking about. We are talking about increasing the funds to the program, but simply not at the rate that they have been increased in the past.

The gentleman from Oklahoma's point about the fact that you can get quality care out of the same dollars I think is a valid one. That in essence is what is occurring in the private sector. If you increase the money as you go along, you ought to be able to get both.

I am interested in the comment Mr. Stropko made about HCFA's ability to create a program that adequately reimburses and would hopefully reinforce quality in the coordinated care programs. I believe you used the term that most people know that that reimbursement structure is flawed.

Mr. STROPKO. Yes, sir.

Chairman THOMAS. Is HCFA currently working on unflawing the reimbursement system, do you know?

Mr. STROPKO. Yes, it has been working on it for the past decade.

Chairman THOMAS. I think that is the point I want to underscore. They have been working on it. In fact, they have been working on it for the past decade and they still have not come up with a better program. We are constantly reminded by my colleague from California, Mr. Stark, how much a model of the bureaucratic form HCFA is, that the administrative costs are low, it is a lean fighting machine that does a great job, and we certainly ought not think about replacing it with anything in the private sector, God forbid, something from a State structure to help it do the job.

Dr. Joyner, I understand that the GAO is going to be releasing a study shortly about HCFA and its performance in the area of administration. Are you going to tell everybody that HCFA is this lean quality machine that ought to be emulated everywhere in the system?

Ms. JOYNER. We are going to be releasing a report looking at its enforcement in risk HMOs. I am not at liberty at this point to say anything about what we will be saying, but we expect to release that on August 3 in hearings before the Senate Select Committee on Aging. We will be glad to come over and brief your staff fully as soon as we have issued that report.

Chairman THOMAS. So we are going to have it released August 3 on the administrative quality of HCFA over HMOs?

Mr. STROPKO. Yes, we are looking at the broad issue of how effective they are in overseeing the HMO Program. We have done this almost every 2 years.

Chairman THOMAS. On how effective they are?

Mr. STROPKO. Right.

Chairman THOMAS. We know that the reimbursement scheme that HCFA has created for the HMOs, in essence, is flawed. Are we going to say that the oversight structure for HCFA is good, or flawed, as well?

Mr. STROPKO. I do not think I am letting anything out of the bag to suggest that there is a lot they could learn from the private sector approaches that we have talked about today.

Chairman THOMAS. So the direction that we are going in terms of taking a look at private sector models and things that are going on in the private sector, in your opinion, is a positive thing, and maybe HCFA does not know everything and perhaps there is a thing or two that HCFA can learn from what has been going on in the outside world?

Mr. STROPKO. Something as simple as letting beneficiaries know what is going on with the HMOs that they are enrolled in is a very positive step that they need to take.

Chairman THOMAS. A little bit of education and assistance in terms of making choices would go a long way toward assisting the beneficiaries in making the right kind of choices.

Mr. STROPKO. And I think making HCFA a lot more effective.

Chairman THOMAS. And HCFA does not do that now?

Mr. STROPKO. No.

Chairman THOMAS. I appreciate your testimony.

The Subcommittees will stand in recess for just a few brief moments, because the gentleman from Florida, Mr. Bilirakis, Chairman of the Health Subcommittee, will be coming back and chairing the second panel. So as soon as he gets here, we will begin the second panel.

The Subcommittees stand in recess.

[Recess.]

Chairman BILIRAKIS [presiding]. We are going to continue on here.

If they have not left, I would like to call the next panel: Margaret E. O'Kane, president of the National Committee for Quality Assurance, and Dennis O'Leary—two Irish names—president of the Joint Commission on Accreditation for Healthcare Organizations, Oakbrook, Illinois.

With your indulgence, I know I am only here at the outset to listen to you, but you are also probably experienced with how we do things up here, unfortunately. Many of the others will be right back.

In the interest of time, we will maybe kick it off. Ms. O'Kane.

## STATEMENT OF MARGARET E. O'KANE, PRESIDENT, NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Ms. O'KANE. Good morning, Chairman Bilirakis.

My name is Margaret O'Kane. I am president of NCQA, the National Committee for Quality Assurance.

As Congress and the administration look to increase the use of managed care in the Medicare Program, I commend both Subcommittees for convening this hearing on the standards for health plans providing coverage to Medicare beneficiaries.

NCQA is an independent nonprofit organization which oversees two complementary approaches to health plan evaluation, accreditation, and performance measurement. NCQA accreditation examines the heath plans' infrastructure, while clinical and service performance are measured through our health plan employer data and information set.

NCQA is governed by a broad-based board of directors which includes large purchasers, health plan representatives, a consumer representative, a State legislator, a union representative, an AMA representative, and independent quality experts.

By the end of this year, we will have accredited nearly one-half of the Nation's health maintenance organizations against a set of rigorous and evolving standards. I should mention that this is a new accreditation program which was launched in 1991.

This figure includes 80 health plans which currently enroll two-thirds of the Medicare beneficiaries and TEFRA risk contracts. The NCQA standards are divided into six sections: (1) Quality improvement, how well does the plan manage and improve quality throughout the health plan, does it coordinate all parts of the delivery system, which is a very important issue for the Medicare population; what steps does it take to make sure members have access to care in a reasonable amount of time; (2) credentialling, how does the plan meet specific requirements for investigating the training and experience of the physicians in its network, how does it choose hospitals and other provider organizations; (3) member rights and

responsibilities, how clearly does the plan inform members about how to get services, how to choose a physician or change physicians, and how to make a complaint; how responsive is the plan to member satisfaction ratings, how effectively does it handle member complaints and grievances; (4) utilization management—does the plan use a reasonable and consistent process when deciding what health care services are appropriate for individual needs; when the plan denies payment for services, does it respond to member and physician appeals; are physician consultants from the appropriate specialty areas used when these decisions are made; (5) preventive services, does the plan encourage members to have preventive tests and immunization, does the plan ensure that its physicians are encouraging and delivering preventive services; and (6) medical records, how consistently do records kept by the physicians meet NCQA standards for quality care.

Approximately one-third of health plans reviewed against standards have received full accreditation, and 13 percent of the plans that have applied have been denied. The results of our accreditation process are available free of charge to any individual who phones or writes our officers, and summary reports for every plan reviewed after July 1 will be made available in 1996. We are committed to providing information in the marketplace.

The primary reason that so many health plans have undergone such a rigorous process is the purchasers' interest in ensuring that their employees are enrolled in quality organizations. Large employers such as Xerox, GTE, IBM, Allied Signal, and certain States have required that the health plans with whom they contract seek NCQA accreditation.

In addition to accreditation, we have developed a standardized system for measuring health plan performance, the health plan employer data and information set, which contains information on quality, access, patient satisfaction, and health plan management.

While HEDIS, the Health Plan Employer Data and Information Set, was initially designed for commercial purchasers, we are committed to broadening this set of measures to address the needs of all payers, including Medicare and Medicaid. We are working with the Packard Foundation and are just releasing for comment a set of measures particularly geared to the Medicaid population, and we are about to launch an initiative to address the special issues of the Medicare population with some funding from the Kaiser Family Foundation.

The framework for the development of HEDIS will come from our Committee on Performance Measures, which is again a broad-based group of experts, which includes corporate purchasers, health plans, AARP, consumers, other consumer organizations, CalPers, and a State Medicaid director. Our approach really is to develop a broad consensus between the health plans and the purchasers.

I think I am out of time, so I will be submitting this testimony and am happy to respond to questions.

Chairman BILIRAKIS. You are certainly welcome to summarize, if you have something else you would like to say.

Ms. O'KANE. The two methods we use to evaluate health plans are both based on the premise that a health plan is responsible and

accountable for the quality of care and service that its members receive.

Many of the options now under consideration by Congress and the administration would encourage a wider variety of managed care organizations such as PPOs to enter the Medicare market. One of our concerns is that HMOs, which really have come forward for this measurement and have been willing to be held accountable, might be subjected to an additional measurement burden when compared to the other managed care alternatives that you are planning to allow in the Medicare marketplace.

There is sort of a perverse problem when you have people that are able to be measured having more reporting burden than those that are not able to be measured, and I think this is not an easy problem to solve. You cannot just say overnight that organizations that have not been able to measure should be held accountable, especially if they do not have the infrastructure. But I do think this is a serious issue that ought to be addressed as you try to move forward.

Thank you.

[The prepared statement follows:]

## STATEMENT OF MARGARET E. O'KANE, PRESIDENT NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Good morning Chairman Thomas, Chairman Bilirakis, and members of the Subcommittees. I am Margaret E. O'Kane, President of the National Committee for Quality Assurance (NCQA). As Congress and the Administration look to increase the use of managed care in the Medicare program, I commend both Subcommittees for convening this hearing on the standards for health plans providing coverage to Medicare beneficiaries.

NCQA is an independent, non-profit organization which oversees two complementary approaches to health plan evaluation: accreditation and performance measurement. NCQA accreditation examines a health plan's infrastructure, while clinical and service performance is measured through NCQA's Health Plan Employer Data and Information Set (HEDIS 2.0 and 2.5). NCQA is governed by a broad based Board of Directors which includes large purchasers, health plan representatives, a consumer representative, a state legislator, a union representative, an AMA representative, and independent quality experts.

By the end of this year, we will have accredited nearly half of the nation's health maintenance organizations (HMOs) against a set of rigorous and evolving standards. This figure includes eighty health plans enrolling two thirds of the Medicare beneficiaries in TEFRA risk contracts. The NCQA Standards are divided into six sections:

- *Quality Improvement:* What improvements in care and service can the Plan demonstrate? Does the plan full examine the quality of care given to its members? How well does the plan coordinate all parts of its delivery system? What steps does it take to make sure members have access to care in a reasonable amount of time?

- *Provider Credentials:* Does the Plan meet specific NCQA requirements for investigating the training and experience of all physicians in its network? Does the Plan keep track of all physicians' performance and use that information for their periodic evaluations? Does the Plan look for any history of malpractice or fraud? Has the Plan performed a quality assessment for health delivery organizations such as hospitals, home health agencies, nursing homes, and free-standing surgical centers?

- *Members' Rights and Responsibilities:* How clearly does the Plan inform members about how to access services, how to choose a physician or change physicians, and how to make a complaint? How responsive is the Plan to members' satisfaction ratings and complaints? Does the appeals process for grievances include a second review with different individuals?

- *Utilization Management:* Does the Plan use a reasonable and consistent process when deciding what health care services are appropriate for individuals needs? Are appropriateness criteria clearly documented and available to participating physicians? When the Plan denies payment for services, does it respond to member and physician appeals? Are physician consultants from the appropriate specialty areas of medicine and surgery utilized as needed?

- *Preventive Health Services:* Does the Plan encourage members to have preventive tests and immunizations? Does the Plan ensure that its physicians are encouraging and delivering preventive services?

- *Medical Records:* How consistently do medical records kept by the plan's physicians meet NCQA standards for quality care? For instance, do the records show that physicians follow up on patients' abnormal test findings?

Approximately one third of health plans reviewed against our standards have received Full Accreditation and thirteen percent have been denied. The results of our accreditation process are available free of charge to any individual who phones or writes our offices, and summary reports for every plan reviewed after July 1st will be made available so that purchasers and consumers will have even more information with which to evaluate health plans.

The primary reason that so many health plans have undergone such a rigorous process is the purchasers' interest in ensuring that their employees are only enrolled in a quality organization. Large employers such as Xerox, GTE, IBM, Allied Signal, the States of New York, Tennessee, and many others have all required that the health plans with whom they contract seek NCQA accreditation.

In addition to accreditation, NCQA has developed a standardized system for measuring health plan performance, the Health Plan Employer Data and Information Set (HEDIS). HEDIS 2.5 is a set of sixty standardized measures of health plan performance in five areas. More than two thirds of the nation's HMOs are now using HEDIS to generate performance information. HEDIS covers five areas of a health plan's performance: **Quality, Access and Patient Satisfaction, Membership and Utilization, Finance, and Health Plan Management and Activities**.

While HEDIS 2.5 was initially designed for commercial purchasers, we are committed to a performance measurement tool which addresses the needs of all populations served by a health plan, regardless of the payor relationship. With funding from the Packard Foundation and in conjunction with HCFA and the State Medicaid Directors Association, NCQA just released a draft set of Medicaid HEDIS measures for review and comment. In addition, we are in the final stages of discussions with HCFA and the Kaiser Family Foundation for the development of Medicare HEDIS measures to be incorporated into HEDIS 3.0.

The framework for the development of HEDIS 3.0 will come from NCQA's Committee on Performance Measurement. The Committee on Performance Measurement is a broad based group of experts charged with overseeing the development of the next generation of health plan performance measures (HEDIS 3.0). In addition to corporate purchasers, health plans, providers, labor, AARP, CalPers, and a state Medicaid Director, we are pleased to have the director of HCFA's Health Standards and Quality Bureau as a member of the Committee.

The two methods NCQA uses to evaluate health plans, accreditation and performance measurement, are both based on the premise that a health plan is responsible and accountable for the quality of care and service that its members receive. Many of the options now under consideration by Congress and the Administration would encourage a wider variety of managed care organizations, such as PPOs, to enter the Medicare market.

We are concerned that HMOs which have made accreditation and performance information publicly available, could be held to a higher set of standards than less "accountable" health plan model types. All health plans, regardless of their financing and delivery structure, should be held accountable for the quality of care and service, and required to provide data on their performance. A central goal of Medicare reform should be to reward health plans for making themselves more accountable to the federal government and beneficiaries. Easing the standards for less accountable health plans would have the opposite effect.

As I mentioned earlier, NCQA will have accredited over half the nation's HMOs by the end of this year; a figure which includes health plans responsible for 66 percent of the seniors enrolled in TEFRA Medicare Risk Contracts. While NCQA Accreditation should not be a condition of participation in the Medicare program, health plans which have achieved accreditation should not be subjected to redundant HCFA certification processes.

Such a consolidation would minimize the administrative burden on health plans, while at the same time providing HCFA with a body of expert knowledge and experience. Federal oversight resources could then be re-allocated to higher priority areas such as new health plan model types, new entrants into the Medicare market, or existing plans experiencing large gains in Medicare enrollment. A model for this public/private partnership already exists in six states (PA, FL, OK, KS, RI, VT) where NCQA works closely with health plan regulators. Just as these states have coordinated their regulation of health plans with NCQA accreditation to eliminate duplication and increase efficiency, so too should the federal government.

NCQA recognizes that reducing the rate of growth in the Medicare program is a critical component of deficit reduction efforts, and we believe there is real potential to reduce costs and improve quality through the use of managed care. However, I urge both Subcommittees to build on the work of this hearing and ensure that efforts to reduce costs do not compromise quality in the process.

Thank you again for the opportunity to testify.

Chairman BILIRAKIS. Thank you very much, Ms. O'Kane.
Mr. O'Leary.

**STATEMENT OF DENNIS O'LEARY, M.D., PRESIDENT, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, OAKBROOK, ILLINOIS**

Dr. O'LEARY. Thank you, Mr. Chairman.

I am Dennis O'Leary, president of the Joint Commission on Accreditation of Healthcare Organizations. We appreciate the opportunity to appear before this joint Subcommittee hearing on standards for health plans providing services through the Medicare Program.

I would like to leave you with two messages today. The first is that progressive advances in quality evaluation techniques have to date provided accreditors with sophisticated and meaningful mechanisms for overseeing the quality related performance of health plans, mechanisms that are fully capable of addressing the priority concerns of the Medicare population.

Second, there is a need to standardize the quality evaluation framework for Medicare managed care plans to assure consistent and relevant oversight of these plans. Health plans and other emerging delivery systems are poised to plan an increasingly important role in the future of American health care. The Nation, therefore, has a vested interest in ensuring that health plans provide the high quality of services that Americans have come to expect.

This is especially true for the Medicare Program, if there is an intent to encourage and sustain greater enrollment in managed care arrangements. Quality measurement and public disclosure of how well the health plans accomplish quality goals provide the opportunity for educated decisionmaking by consumers, and offer a means to track their own performance against the established goals.

However, the trend toward vertical integration of services creates new challenges for quality evaluation. Health plans have new responsibilities for integrating services across multiple sites of care and for assuring that the needs of their enrollees are met. How well a plan performs these and other key functions has a large bearing on enrollee outcomes, the cost of providing services, and the eventual health status of the population served.

We also need to remember that health plans share a common incentive in seeking to determine the appropriate intersection between cost containment and quality. This incentive creates risk; that is, what makes a plan successful in controlling its costs also causes exposure to quality concerns. There is a growing belief among major private sector purchasers that the progress already made in paring down system costs has led us to a mandate for vigilant quality oversight initiatives.

Groundbreaking efforts in recent years, both in creating performance-based standards and in developing performance indicators, now provide the tools for effective quality measurement and permit the evaluation of quality across a spectrum of health plan configurations. This capability will be essential, as innovative ap-

proaches to delivering and financing cost-effective health care emerge.

The thorough evaluation approach for health plans and more complex delivery entities should address two broad areas, performance of key organization functions and patient/enrolling outcomes. The former requires the application of contemporary standards, and the latter involves the use of carefully selected performance indicators.

Evaluation of each of these areas provides essential and often complementary information. Together, the two measurement approaches form the fundamental basis for effective quality review in both the fee-for-service and managed care sectors.

To ascertain the likelihood that a health plan will achieve their future results, one must evaluate organization functions that are basic to both the clinical services provided to enrollees and to the management of the organization. In developing standards around key functions that all health plans must perform and by articulating them as performance objectives, we have established a basis for evaluating quality without prejudice to how the provider is structured or even how the provider undertakes to meet the expectations.

The government has the potentially important role in standardizing the quality measurement framework for health plans participating in the Medicare Program. To this end, the Secretary of Health and Human Services, acting through existing agencies and in conjunction with States, consumers, and private sector experts, could, and we believe should articulate quality expectations for health plans.

These expectations should include both minimal standards and a menu of consensus outcomes measures applicable to the full range of health plans. The government should not feel the need to establish any new oversight bureaucracy. Rather, its determination as to minimum standards and consensus outcomes measures should permit a judgment as to the desirability of reliance on private sector entities to perform evaluations of health plans, using at a minimum the explicit expectations of the Medicare Program. The remaining responsibility of government would then be to oversee its delegated evaluation agents to ensure its satisfaction with their performance in providing quality oversight of health plans.

The private sector is well prepared, we believe, to evaluate the array of emerging variations of managed care plans. Our cutting-edge standards permit us to evaluate the centralized "brain" of the plan, the functions pertinent to its successful operations, and the performance of providers in all of the component delivery sites in a plan or system, such as hospitals, nursing homes, and home health agencies.

Chairman BILIRAKIS. Please summarize.

Dr. O'LEARY. Throughout the Nation, restructuring of health care delivery is taking place. New options are being considered for the Medicare Program. Meaningful quality evaluation is essential to the success of and public confidence in the new delivery models.

The Joint Commission has previously worked in successful collaboration ventures with the public sector and is prepared to do so in this area. We believe there is a rich opportunity to design an effective quality evaluation and improvement system that will build public confidence in Medicare managed care plans, while continually upgrading the level of care provided to our Nation's elderly and disabled citizens.

Thank you.

[The prepared statement follows:]

**STATEMENT OF DENNIS O'LEARY, M.D.**
**PRESIDENT, JOINT COMMISSION ON ACCREDIATION OF HEALTHCARE ORGANIZATIONS**

I am Dr. Dennis O'Leary, President of the Joint Commission on Accreditation of Healthcare Organizations. We appreciate the opportunity to appear before this joint committee hearing on standards for health plans providing services through the Medicare program.

I would like to leave you with two messages today. The first is that progressive advances in quality evaluation techniques have today provided accreditors with sophisticated and meaningful evaluation approaches for overseeing the quality-related performance of health plans -- approaches that are fully capable of addressing the priority concerns of the Medicare population. Second, there is a compelling need to standardize the quality evaluation framework for Medicare managed care plans to assure consistent and relevant oversight of these plans.

Health plans and other emerging delivery systems are poised to play an important role in the future of American health care. The nation, therefore, has a vested interest in ensuring that health plans and their hands-on care sites provide the high quality of services that Americans have come to expect. This is especially true for the Medicare program if, as a matter of public policy, we wish to encourage and sustain greater enrollment in managed care arrangements.

The potential impact of health plans is significant. The capitated payment systems that characterize most integrated delivery models provide strong incentives to keep patients healthy by focusing on wellness, prevention and early intervention. Health plans are also in a unique position to coordinate care along the entire continuum of service delivery. Quality measurement and public disclosure of how well the health plans accomplish these and other quality goals will provide the opportunity for educated decision making by consumers in selecting among their options, and will offer a means for plans to track their own performance against established goals.

However, the trend toward vertical integration, coupled with growing purchaser and consumer demands for information about value, creates new challenges for quality measurement. Health plans are complex entities that are more than the sum of their parts; they have new responsibilities for integrating and coordinating services across multiple and differing sites of care, and for assuring that the needs of their enrollees are met along the full continuum of care. How well a plan performs these and other key functions has a large bearing on enrollee outcomes, the cost of providing effective and appropriate services, and the eventual health status of the population served.

Health plans can take a variety of forms, and some of these are not fully tested. They share a common incentive, however, seeking to determine the appropriate intersection between cost containment and quality. This incentive creates risk; that is, what makes a plan successful in controlling its costs, also causes exposure to quality concerns. There is in fact a growing belief among major private sector purchasers that the progress already made in paring down system costs has led us to a mandate for vigilant and substantive quality oversight initiatives.

Performance measurement is usually undertaken for two primary reasons: as a basis for making decisions and to serve as a basis for quality improvement. In the ideal world, consumers, purchasers, and other stakeholders would make a range of decisions about health care plans based on measurement information about various aspects of organization performance. In addition, these measurements of quality would provide plans with useful, comparable information upon which to base internal quality improvement activities. Ground breaking efforts in recent years -- both in creating performance-based standards and in developing performance indicators -- now provide the tools for reaching those goals of quality measurement, and permit the evaluation of quality across a spectrum of health plan configurations. This capability will be essential as innovative approaches to delivering and financing cost-effective health care emerge.

A thorough evaluation approach for health plans and more complex delivery entities should address two broad areas: *performance of key organizational*

*functions* and *patient/enrollee outcomes*. The former requires the application of contemporary standards, and the second involves the use of carefully selected performance indicators. Evaluation of each of these areas provides essential, and often complementary information. Together, the two measurement approaches form the fundamental basis for effective quality review and assessment in both the fee-for-service and managed care sectors.

Performance of Key Organizational Functions

To ascertain the likelihood that a health plan will achieve good future results, one must evaluate organizational functions that are basic to both the clinical services provided to enrollees and to the management of the organization. The performance of these systems and processes, such as credentialing of practitioners, management of information, and patient assessment, is usually measured by assessing compliance with relevant standards. For health care organizations, a standard is a statement of expectation that defines the processes that must be functioning well in order to optimize the likelihood of good outcomes. In developing standards around key functions that all health plans must perform, and by articulating them performance objectives, we have established a basis for evaluating quality without prejudice as to how the provider is structured or even how the provider undertakes to meet the expectations. This is designed both to encourage the organization to have an accountable locus of responsibility for its performance in providing services, and to stimulate innovation in the creation of cost-effective delivery models.

Patient/Enrollee Outcomes

Information on patient/enrollee outcomes is necessary to complement the information gathered from an assessment against performance standards. Outcomes are the product of the performance of clinical services and management functions, and are understood to include certain measures of process (e.g., staging of cancer for appropriate treatment selection) that are proxies for likely outcomes (e.g., survival). An advantage to outcomes data is that it can be monitored routinely between the onsite visits made to assess compliance with standards. Such data thus is available to support internal quality improvement activities in the health plans, and to provide external assurances that plan performance is being sustained or improved.

The Measurement Framework

A potential role of the government is to help standardize the quality measurement framework for health plans participating in the Medicare program. Toward this end, the Secretary of Health and Human Services, acting through existing agencies and in conjunction with states, consumers, and private sector experts could, and we believe should, articulate quality expectations for health plans and their component providers. These expectations should include both minimal standards and a menu of consensus outcomes measures applicable to the full range of health plans. This need not be a costly effort. To accomplish this task, the government could borrow from the substantial work already done in the private sector. For example, accrediting organizations have already created a comprehensive array of quality standards for health plans.

Neither should the government feel a need to establish any new oversight bureaucracy. Rather, its determination as to minimum standards and consensus outcomes measures (performance indicators) should permit a judgment as to the desirability of reliance on private sector entities to perform evaluations of health plans, using, at a minimum, the explicit expectations of the Medicare program. The remaining responsibility of government would then be to oversee its delegated

agents to ensure its satisfaction with their performance in providing quality evaluation and oversight of health plans.

The private sector is well prepared, we believe, to evaluate the array of emerging variations of managed care plans. The Joint Commission has developed a top-to-bottom adaptable capability for measuring quality in new delivery system models, regardless of their financing arrangements. Our cutting-edge standards permit us to evaluate the centralized "brain" of the plan, the functions pertinent to its successful operation, and the performance of providers in all of the component delivery sites in a plan or system, such as hospitals, nursing homes, and home health agencies. With the current changes taking place in the health care system, we believe that a solid oversight program must include direct evaluation of actual delivery sites as part of plan evaluation. Our accreditation process involves this type of review.

The Joint Commission has been the leader in developing performance-based standards, and we recently completed the redesign of our standards manuals for the more than 11,000 health care organizations we accredit. The standards are patient focused and are stated as performance objectives rather than as inflexible requirements. The Health Care Financing Administration has also begun to recast its standards for certain health care facilities, such as hospitals, along similar lines. Further, the Joint Commission has taken a leadership role in the area of public disclosure of standards compliance information through the development of performance reports on accredited organizations. These activities and others provide ample evidence that accrediting bodies continue to be at the leading edge of advances in quality evaluation.

## The Near Future in Quality Measurement

Both regulators and accreditors are now aggressively moving toward the development, testing and broad application of outcomes measures and other performance indicators as integrals of the modern quality oversight approach. The Joint Commission has been a pioneer in the development of performance indicators, especially for inpatient care. However, the population-based nature of managed care plans requires a more elaborate range of indicators capable of addressing a continuum of services. On the positive side, prolific efforts in recent years have yielded an inventory of hundreds of indicators that are now available for potential use in managed care settings. On the cautionary side, considerable work remains to be done to evaluate these performance indicators against the dimensions of reliability, validity, discrimination capability, and the benefit-to-burden balance. With the right partners at the table, we believe that the Medicare program could rapidly assimilate the work currently being done by accrediting organizations, to the benefit of the Medicare population.

Specifically, there is a need for outcome measures that will lead to improved patient care for the Medicare population, while at the same time optimizing the resources available to support data gathering and quality improvement activities. We see an important potential role for the federal government in establishing a simple forum for arriving at an acceptable menu of performance indicators applicable to the Medicare population. This type of public/private sector collaboration could be achieved quickly, potentially placing Medicare at the forefront of quality measurement in all of its health care programs.

Along similar lines, the Joint Commission undertook a pilot project in 1993 with a number of stakeholders interested in developing consensus performance indicators for use in evaluating health plans and other emerging entities. The work group agreed upon eleven principles (see addendum) that should shape the measurement framework for the Joint Commission's new accreditation activities in this area. These principles then provided the structural underpinning for identifying those measurement categories for indicators to complement the already-established performance-based standards. These categories included:

+ clinical performance, including prevention, early detection,

appropriateness of care, and effectiveness of treatment.

+ functional status
+ satisfaction of enrollees, practitioners, and purchasers

Indicators within these categories could be general or can relate to specific disease states. The work group also identified a set of priority medical conditions that should be targeted for measurement.

Confidence in performance indicators will only be achieved when there are adequate numbers of relevant and well-tested indicators that can offer a full profile of health plan performance. With respect to health plans, this will require the gathering and, as appropriate, adaptation of existing measures and the design of new ones to fill in any gaps in the measurement framework. The Joint Commission has begun this task by gathering information from existing databases of outcomes measures, and by establishing a process to determine the specific criteria against which indicators will be judged.

The Joint Commission's long-term objectives are to use outcomes and other performance data to focus the on-site evaluation of the health plan standards compliance, and eventually to create a continuous accreditation process. Standards compliance is generally a good predictor of future good outcomes. Where outcomes are less than satisfactory, this information can rapidly point to areas where processes are not functioning properly (i.e., failed standards compliance) and set the stage for performance improvement. Such improvement initiatives need not occur periodically (that is, awaiting the next survey) but can, and should occur on a real live basis as outcomes data are monitored continuously. The Joint Commission is beginning to field test a continuous accreditation model in central Pennsylvania where over 40 organizations have already agreed to participate.

Throughout the nation, restructuring of health care delivery is taking place. Spurred by market forces, as well as by state reform initiatives, provider organizations, practitioners and insurers are coming together in a variety of innovative organizational structures to form new and increasingly complex delivery systems. New options are also being considered for the Medicare program. Meaningful quality evaluation is essential to the success of, and public confidence in, the new delivery models. The private sector's accrediting bodies have developed and are using, relevant quality evaluation tools in the form of performance-based standards and outcomes measures. We have previously worked in successful collaborative ventures with the public sector and are prepared to do so in this area as well. Working as a public/private partnership, we believe there is a rich opportunity to design an effective quality evaluation and improvement system that will build public confidence in Medicare managed care plans while continually upgrading the level of care provided to our nation's elderly and disabled citizens.

ADDENDUM

Principles for Performance Measurement of Health Care Networks

1. Measurement of health status and health care quality are essential to the improvement of health care.
2. The design of any meaningful measurement system must involve all key stakeholders, including purchasers, providers, evaluators, consumers, and government.
3. A basic requisite to the creation of a measurement system is the establishment of a national framework within which measurement priorities can be determined and measures developed.
4. The measurement framework must be applicable to networks and components of networks; useful to purchasers and consumers in evaluating the quality of networks and their components; useful to government in formulating and assessing public health policy; and useful to providers in improving care.
5. The measurement framework must promote efficient and concise measurement that minimizes the associated administrative burden.
6. The measurement framework must promote the accountability of both the network and the stakeholders of the network.
7. The measurement process should include definition of the individual or unit accountable for each specific measure.
8. The measurement system should be able to describe the health benefits achieved both by individuals and the population served by the network.
9. Data system used for quality measurement and comparison must be built on relevant measures that meet established criteria for reliability, validity, and ease of data collection.
10. Data collection must focus on those data necessary for the measures, rather than those data most readily available.
11. The measurement system must constantly anticipate its own improvement.

Source: Joint Commission on Accreditation of HealthCare Organizations 1993 workgroup on identifying indicators for use in the network accreditation program.

SELECTED CRITERIA FOR EVALUATING INDICATORS

| | | |
|---|---|---|
| Relevance | - | Applicability and pertinence of the indicator |
| Reliability | - | Ability of the indicator to accurately and consistently identify the events it was designed to identify across multiple settings |
| Validity | - | Extent to which the indicator raises legitimate questions about the quality of care provided and the extent to which opportunities for improvement are identified. |
| Discrimination Capability | - | Extent to which indicator shows significant variation in performance across multiple networks |
| Benefit/Burden Balance | - | Importance of the measure balanced against the accessability of needed data elements, the relative effort required to abstract or collect the data, and the associated costs. |

Chairman BILIRAKIS. Thank you very much, sir.

Ms. O'Kane, what level of acceptance would you say that the NCQA has in the industry?

Ms. O'KANE. Well, I think we have been controversial in the industry to some degree in terms of we are willing to draw lines. As you might imagine, some plans have not come out as well as others in this process. So while there is a lot of support in the industry, we are not universally loved.

I think a quality oversight organization that was universally loved probably would not be doing its job.

Chairman BILIRAKIS. I was in the aerospace industry for many years as an engineer, as well as a lawyer, and the quality assurance people were never really the most loved in the organization.

Dr. O'Leary, what does your group think about the NCQA?

Dr. O'LEARY. We have high regard for our colleagues in this arena. We have collaborated on a variety of arenas, not in actually performing evaluations, but I think we see eye-to-eye pretty much on the standards base and the measurement base. In fact, I believe you will see a lot of similarities between our standards for managed care networks and between our respective measures.

Chairman BILIRAKIS. Ms. O'Kane, I have sort of glanced over your written testimony here, and I understand that you are currently in the process of accrediting 80 health plans.

Ms. O'KANE. Eighty health plans that have Medicare risk contracts. There are about 200 health plans.

Chairman BILIRAKIS. Which enroll about two-thirds of the beneficiaries in risk contract HMOs.

Ms. O'KANE. Yes.

Chairman BILIRAKIS. By the way, I think Mr. Waxman used the figure like 2 percent of Medicare beneficiaries are in managed care. I believe that figure is about 9 percent.

Ms. O'KANE. I thought so, too.

Chairman BILIRAKIS. In any case, do your standards differ in any way from those set by HCFA for these HMOs?

Ms. O'KANE. Yes, they are considerably different. When we wrote out standards, which was in 1990, we basically went through a process of reviewing HCF's oversight standards, some of the Joint Commission standards, and other organizations that do quality review. We particularly paid attention to what many Fortune 500 companies were doing in terms of evaluating the quality of the health plans that they offered, because many of them were really at the cutting edge, in our view.

So we like to think our standards advance the state of the art. They really are very quality improvement oriented, as well. I think there is some degree of overlap with the quality oversight process within the Federal qualification and Medicare certification process, but also considerable divergence.

Chairman BILIRAKIS. But where there is, shall we say, a clear distinction—I hate to use the term disagreement, but clear distinction between certain standards, who basically controls it? Does HCFA basically control, because they are the government?

Ms. O'KANE. Yes, they wrote their own. I believe that came out of their regulatory processes.

Chairman BILIRAKIS. I see. Is that good?

Ms. O'KANE. Obviously, we believe ours are better, of course we do. We just went through a big process of rewriting them and we think they are really quite good. This is a complicated business and there is always room for improvement.

Chairman BILIRAKIS. When I asked my first question regarding the industry and your acceptability—and that is not intending to just refer the providers, I also was thinking in terms of beneficiaries, the consumer, and that sort of thing—what is your status with those?

Ms. O'KANE. Well, we get increasing numbers of consumer calls because we have had more press coverage lately.

While we are on the topic of consumers, we have been doing a lot of focus groups with consumers asking them about what kind of quality information they would like to have when they choose a health plan. I think particularly for the Medicare population, there really needs to be a lot of attention to educating consumers about what to look for when they are choosing a health plan, especially if a lot of consumers are going to be moving into Medicare managed care. I think some thought ought to be given to some kind of information broker organization that could actually help people sort through the information that is increasingly going to be made available. Because I think the information is complicated and there could be a reaction that it is too confusing, and I do not want to deal with it. So I would urge you to consider that.

Chairman BILIRAKIS. Certainly. If it is complicated now, it may tend to be a little more complicated as we are talking about these additional choices, and certainly it is not our intent to do that. I just hope we do a good enough job of it.

The gentleman from Wisconsin.

Mr. KLECZKA. Thank you, Mr. Chairman.

The previous panel, in response to a question from one of the Members of the Subcommittee, indicated that in the Medicare Program there is about 10 percent fraud, waste, and abuse. Would either of you in your professional judgment be able to speak to that? I am trying to ascertain whether or not it is realistic to say that it is 10 percent or something close to that.

Ms. O'KANE. I do not really have any basis for shedding any additional light on it. I would agree with the statements that they made that that is the number on the street, but it is obviously really hard to know for sure whether all fraud has been uncovered, so it is a speculative number.

Mr. KLECZKA. Dr. O'Leary.

Dr. O'LEARY. Neither one of us has standards that specifically address or have the ability to ferret out financial fraud and abuse kinds of issues.

Mr. KLECZKA. Let us leave aside for the moment the Medicare Program. How about in the private insurance market, HMOs, and managed care type operations, would a 10-percent figure be comparable there also?

Ms. O'KANE. That seems to be the consensus number, the conventional wisdom again. There may be some variation between the private and public sector, I would imagine there might be.

Mr. KLECZKA. Like how much variation?

Ms. O'KANE. I cannot say.

Mr. KLECZKA. So you do not really know if there is any?

Ms. O'KANE. I really do not know much about this at all.

Mr. KLECZKA. Let us say it is somewhere in the vicinity of 10 percent. Where in your estimation would the bulk of the fraud be coming from? Is it from providers, is it from a particular group of providers? If I wanted to divvy up 10 percent, who would I attribute the problem to?

Ms. O'KANE. I guess I think that there is fraud and abuse in the system, I think that the major opportunities for improving the value we get in health care comes from getting rid of some of the costs of poor quality. I think that there are many costs in the system of poor quality, unnecessary bad things that happen to patients like wound infections in the hospital that could have been prevented. I think there are just enormous opportunities.

Mr. KLECZKA. But that would not be waste or fraud. That is just poor medical care.

Ms. O'KANE. That is what I am saying.

Mr. KLECZKA. Let us go back. I am trying to ascertain who is responsible for it. Is it the providers? Can we say that the doctors are at 5 percent, medical suppliers are 3 percent?

Ms. O'KANE. I do not know that there is any particular number that would be true nationwide. It probably varies in local situations. I do not have anything really to shed on the subject.

Dr. O'LEARY. I do not have any information, either. I think that those who are inclined to commit a crime are not readily categorized and are more on an individual basis. You may be an individual practitioner, you may be running a group, you may be running an organization, you might be an insurer. People are inclined to commit crimes. The system does not have tight controls on it to prevent those crimes and they will occur.

Mr. KLECZKA. In your estimation, is there any opportunity for the beneficiaries themselves to engage in fraud and abuse?

Dr. O'LEARY. I think there are opportunities.

Mr. KLECZKA. Like where?

Dr. O'LEARY. Well, it is not an area that I have studied particularly, but I think that mechanisms for payment and reimbursement are complex. I have been a user of the delivery system and my family has, and you can see that the system is not tightly run to prevent duplicative payments, for instance.

Mr. KLECZKA. But the payments would go to providers and the only way the beneficiary would share in the fraud and abuse would be if in fact they are in concert with the provider.

Dr. O'LEARY. No, that is not true. There are times when the beneficiary pays or alleges to have paid a provider and seeks reimbursement directly from an insurer or from an HMO. That really does happen. I can see opportunities for at last petty larceny in the system. I do not know whether we are talking about a lot of money, but these systems are complex and complex systems have a tendency to die under their own weight.

Mr. KLECZKA. I am aware that this panel did not make the statement and the other panel was gone by the time I got to my second round, so I thank you for shedding a little light on it.

Chairman BILIRAKIS. I thank the gentleman.

The gentleman from Louisiana, Mr. McCrery.

Mr. McCRERY. Thank you, Mr. Chairman.

Ms. O'Kane, can you give us your opinion of how effective a mechanism the 50–50 rule is as a means of assuring quality?

Mr. O'KANE. Well, I think it has played some mitigating role perhaps, although it is a crude way of ensuring quality. As we evolve the ways that we can look at quality, I think that the 50–50 rule will become less pressing, although there was a certain logic to the 50–50 rule when it was put in place.

Mr. McCRERY. And what was that logic?

Ms. O'KANE. I believe that the logic was that an organization that could hold commercial enrollees would have to be providing a certain level of quality and would have to have a certain infrastructure, so that presumably some of that could impact, would spill over onto the Medicare population.

Mr. McCRERY. In other words, the rationale was that when you say commercial enrollees, you are really talking about private sector enrollees——

Mr. O'KANE. Right.

Mr. McCRERY [continuing]. People that are not in government programs, but are in private sector programs.

Ms. O'KANE. Right.

Mr. McCRERY. The rationale was that those private sector enrollees would demand quality and therefore assure a certain level of quality that would then trickle down, shall we say, to the government enrollees?

Ms. O'KANE. I suppose, yes.

Mr. McCRERY. As we hear more from the private sector about ways to measure quality, and we are talking today a little bit about how the government can catch up to the private sector, it really concerns me that we are studying another government mechanism or structure to put in place. We have found through the years that as the government puts in place a structure or a mechanism, it is sometimes quickly outdated. Can you give us any insight as to how we create a mechanism or how we keep from locking in a mechanism that might work well today, but soon becomes outdated?

Dr. O'LEARY. I think that what you need is an adaptable mechanism that does not create a hierarchy nor add people. Our experience in working with HCFA, for instance, in hospital oversight, is that HCFA has required relatively little staff in order to run a pretty effective oversight program in the private sector.

I see the role of government in this arena as being the standardization of the measurement tools that are going to be applied; to work with the private sector in determining what those should be, and then putting them in place and using that as the reference point; then determining who in the private sector is capable of carrying out evaluation against those standards, and even spot checking our performance. That is not an elaborate system, but it has the checks, balances, and oversight that permits the government to meet its oversight responsibilities.

Ms. O'KANE. May I answer that?

Mr. McCRERY. Sure.

Ms. O'KANE. I think we agree with the implication in your question that there is a real opportunity here for the public and the private sectors to work together and for the public sector to benefit

from the ability of organizations like ours to move quickly to advance the state of the art and to respond to changing conditions in a way that we seem to be able to do more effectively maybe, because we do not have to go through the political process.

Mr. MCCRERY. Thank you. I certainly would not mean to imply anything with my questions, but I appreciate your responses.

Chairman BILIRAKIS. I thank the gentleman.

Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. O'Leary, in your testimony, you argue that there is no need to create new standards because organizations such as yours have already developed them and that there is no need to add any new oversight bureaucracy. If this is the case, how quickly do you believe we could implement a standard system for measuring quality?

Dr. O'LEARY. I think that putting in place a standards based system could occur within months to, at the outside, 1 year. Now, the development of applicable standards, just like the development of applicable performance measures, is an evolving process, so whatever you put in place, you need to have an ability to update over time. But I feel sufficiently confident in the standards that we have for managed care networks and in the ones that NCQA has, to say that those are state-of-the-art standards. Those could be melded together very readily with very little cost to put in place the kind of oversight mechanism that I think people are interested in.

Mr. ENSIGN. Do you think—and this gets back to a little bit earlier questioning—that the Medicare population is a fairly, let us not say cynical, but skeptical group on whether what somebody is telling them is the truth and they can count on the information? Do you think that these are standards of quality that this population would be willing to accept?

Dr. O'LEARY. Yes, I think as long as they understand what they are. My experience in dealing with the Medicare population is that their knowledge base as to available mechanisms and their ability to interpret performance information is limited. I put that burden on us. That is our job, to make sure that they learn about that.

But the kinds of standards that we are looking at are of the most basic, and we are talking about patient rights and responsibilities, organization ethics, patient assessment, patient care, management of information, and performance improvement. This is not esoteric stuff. These are basic fundamental expectations of the performance of any health care organization.

Mr. ENSIGN. Ms. O'Kane, I would like to explore this. You mentioned the cost of poor quality and that whole concept. I would just like to take a couple of minutes and address that with you. In business outside of the health care industry, whether it is manufacturing or the service industry, people understand the cost of quality and actually how much money they can save in the long term with proper management techniques, and with proper systems put in place that people can operate under. That is usually within one organization that you are doing that with, and it is usually top-down driven.

Addressing perhaps those kinds of concepts within the whole Medicare field, we are dealing with all these different companies, all these different doctors, their own bosses, their own type of situation where it is not a top-down driven system.

Ms. O'KANE. I think that while it may not be necessarily top-down and sort of uniform the way a manufacturing firm is, there is a system quality in a good managed care organization that has to be there in order for it to effectively do its job. I think about examples like asthmatics that wind up in the emergency room or admitted to the hospital because their asthma has not been managed effectively. That drives up the costs of the system, and it makes the patients unhappy and very anxious. There is really little good to be derived from a system that is not working in that area.

To use the Medicare example, people with chronic obstructive lung disease also carefully managed on the outpatient side, you can avoid those kinds of crises and that kind of exacerbation which drives up the costs of the system tremendously. There are just multiple examples of chronic illnesses in the Medicare population that, if effectively managed in the outpatient setting, will prevent hospitalizations that are costs for quality.

Mr. ENSIGN. Do you see this then mainly being applicable to a managed care situation and not to the general population, as well?

Ms. O'KANE. Only a managed care population has the system quality so that it is able to find out who are the relevant populations, how do they intervene, which parts of the system are not working, where do they need to put in a case manager, where do they need to put in a patient education program. So you cannot do that in a cottage industry, which is what I believe fee-for-service Medicare is at this point.

Mr. ENSIGN. Thank you.

Thank you, Mr. Chairman.

Chairman BILIRAKIS. I thank the gentleman.

The gentleman from North Carolina, Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Welcome, Ms. O'Kane and Dr. O'Leary. I am fortunate that in Winston-Salem, North Carolina, we just had an insurance company who introduced an HMO plan for seniors, so I have first-hand knowledge of the fact that we can introduce options into the marketplace. I am just curious, has that plan been rated, or is that too new?

Ms. O'KANE. I do not know, but I can get you that information.

Mr. BURR. I would appreciate that.

Ms. O'KANE. I know that we have done some partners plans, but I do not remember if the North Carolina plan has been evaluated or not.

Mr. BURR. I would appreciate it if you could supply that.

[The following was subsequently received:]

CIGNA HealthCare of North Carolina is scheduled to be surveyed on October 7, 1996. Kaiser Foundation Health Plan of North Carolina received provisional acceditation. PARTNERS National Health Plan of North Carolina received provisional accreditation. Personal Care Plan has been surveyed and is awaiting a decision. Prudential Health Care System of Charlotte received full accreditation.

Mr. BURR. Let me go back to a question I asked of the GAO, and it specifically dealt with HCFA trying to replicate the successes of the private sector. I guess what I want to ask you is, as one who is an expert on the quality of plans in the private sector, would you agree with the GAO that HCFA has quite a ways to go to replicate the successes?

Ms. O'KANE. We are very proud of the work that we have done. We think we have advanced the state of the art.

Mr. BURR. I will try one more time, and I certainly understand that you are on a fine line. Seldom do we have somebody whose expertise is in front of us that deals with the quality of care, and I think that the challenge for this Subcommittee is to meet or exceed the current quality of care that is created in the system.

To do that, we must first establish what that quality of care is, and a very important aspect of that is to determine whether HCFA and the fee-for-service plan as currently designed and really underwritten by the Federal Government can be improved, and if in fact the private sector has made advances ahead of the Health Care Financing Administration.

Dr. O'LEARY. I think we always will be ahead, because we have ready access to the kinds of expertise and input that are necessary to build state-of-the-art standards, and we can tap into a wide range of professional expertise, to consumer groups, to purchasers, and we do not have a regulatory bureaucracy to go through in order to put those in place. So we will always I think be on the cutting edge.

My experience and I think my colleague's experience is there has been a lot of interest on the part of HCFA in tapping into what we have been able to develop. The process through which new regulations or conditions of participation are put in place is cumbersome. It takes time and there are a variety of obstacles, and sometimes HCFA seems to fall short I think of both the timeliness and the degree of toughness of its standards.

There is also some philosophy that has been afoot in government that government standards should be minimum standards, and I understand the need for that where you are an enforcing and certifying agency. We are not bound by that and we can engage more in reach-for-the-sky standards, and indeed both of us have standards that are strongly intertwined with quality improvement principles that say that the oversight mechanisms should not create a ceiling. It should be a base upon which organizations build, and private organizations will always have that advantage over the government.

Mr. BURR. So, in fact, the private sector displays much more creativity in its approach to specific problems than in this particular case?

Dr. O'LEARY. We are unshackled in that regard.

Ms. O'KANE. Let me just add, though, that we have been talking to HCFA about working with them jointly on some HEDIS measures that would really address particular concerns of the Medicare population, so I want to make that for the record.

Mr. BURR. I think we would all admit that HCFA has reached out to try to take advantage of some of the lessons that are out there. I think the disagreement we might have with some of the administration is how quickly they understand and if they ever do implement them, and I think that is certainly something we have to find out.

Mr. O'Leary, just one thing, in your testimony you wanted to leave us with two messages. The second one is there is a compelling need to standardize the quality evaluation framework for Medicare managed care plans to assure consistent relevant oversight of these plans. I would just ask you, is there a difference in evaluating the quality of a Medicare managed care plan and an HMO outside of the senior population?

Dr. O'LEARY. For all intents and purposes, no.

Mr. BURR. Let me ask either one of you or both of you: Based upon the work that you do, if you were to rate the current health care plan that we have for seniors in this country, how would it rank from a standpoint of quality assurance?

Ms. O'KANE. Do you mean where we are right now in terms of the way the Medicare Program is working?

Mr. BURR. Yes.

Ms. O'KANE. I could not give it a very high mark.

Dr. O'LEARY. I think if you at least focus on the areas in which we have relationships with the Federal Government, HCFA, I think you are seeing some fairly major changes in——

Mr. BURR. I am asking you to make a decision, if you were to rate it, base it off of where we are today—the point here is can we make progress, can we improve the quality of care for seniors over what they have today?

Dr. O'LEARY. I think the answer has to be yes. My only caveat was I know that there are plans in process to move forward, irrespective of where we are today, that the answer to your question is yes.

Chairman BILIRAKIS. The gentleman's time is expired.

Mr. BURR. I thank both of you. I yield back the remainder of my time.

Chairman BILIRAKIS. They are both shaking their heads yes.

Mr. Thomas, the Chairman of the Ways and Means Subcommittee.

Chairman THOMAS. I thank the gentleman.

I want to continue in that direction in just a slightly different way. It is interesting that most of the examples are of critics who do not want us to really focus on making what I think are positive and healthy changes by turning HCFA inside out, as I say, or relying on the private sector and those who are out there.

What bothers me a lot is that the implication is that, well, folks on Medicare are getting the best quality assurance program, we have got the best administration, and the folks out there in the private sector really—I mean there are a bunch of sleazies out there and the structures that are out there overseeing what is going on, I mean you would not want them, if you really knew what was going on.

I get this constantly from our critics, and it just amazes me that they have to rely on examples of 20 or so years ago to talk about

the state of the industry. Ms. O'Kane, where was your organization 20 years ago?

Ms. O'KANE. Well, this organization existed, but it was not active 20 years ago. It existed on paper, really.

Chairman THOMAS. So clearly with the growth of coordinated care programs in the private sector through the eighties and especially——

Ms. O'KANE. Actually, 20 years ago it did not exist. Excuse me, I did bad math there.

Chairman THOMAS. Around 1975.

Ms. O'KANE. Right. No, it did not exist in the seventies.

Chairman THOMAS. I know how you feel. To me, 10 years ago was 1975, and then someone says no, that was 20 years ago. You did not exist. In fact, you have grown and developed as the approach to the delivery of medicine that you now oversee on quality assurance has grown.

Ms. O'KANE. Right.

Chairman THOMAS. Dr. O'Leary, your organization 20 years ago?

Dr. O'LEARY. We did exist, but we had an accreditation process that you will find very few threads of remaining today. Basically, it has totally revamped itself to focus on performance and on outcomes measures, and we in fact——

Chairman THOMAS. In fact, did you not go through a name change during this period?

Dr. O'LEARY. We went through a radical change during this period of time.

Chairman THOMAS. And name in terms of focus. Were you not originally just looking at hospitals?

Dr. O'LEARY. Looking at hospitals, and today we accredit across seven fields and over 15,000 organizations. Hospitals are a significant segment, but not the majority of what we do.

Chairman THOMAS. So when folks use the examples of horror stories and they have to go back 20 years, I mean the value of that in reflecting on today's marketplace, today's private sector certification and the rest really is not of much value. Do you not think that is true?

Dr. O'LEARY. Yes.

Chairman THOMAS. Then let us take a look at today's performance standards. I understand, Ms. O'Kane, that you mentioned that you accredit 80 health plans which enroll about two-thirds of the Medicare beneficiaries in the TEFRA risk contracts?

Ms. O'KANE. Let me clarify that again, because you were not here. We have accredited about 200 health plans, 80 of which have TEFRA risk contracts.

Chairman THOMAS. Of course, HCFA has to approve those. And where were you in matching up with approval of what HCFA had approved?

Ms. O'KANE. We have not done that analysis, but I just told one of my staff we ought to do that analysis, because I know that there have been discrepancies.

Chairman THOMAS. And discrepancies meaning what, that maybe some HMOs met the Federal standards and actually flunked your standards, that in fact the private sector standards

may be more rigorous and closer to what we are currently looking for on quality standards than what HCFA is doing?

Ms. O'KANE. Yes. I do not know how many cases that happened in, but I know of at least two cases where that happened.

Chairman THOMAS. I hope you move into that study fairly quickly——

Ms. O'KANE. We will have it done by next week.

Chairman THOMAS [continuing]. Because my understanding from the previous panel is we are going to get a GAO study, and it always worries me a little bit when government gives us an opinion. I would love to have a second opinion from the private sector on whether or not their accreditation process seems to give HCFA high marks in terms of the Federal standards, and I look forward to your cursory examination. But my understanding is that—I apologize for speaking over you—is that you know of two instances in which somebody got flying colors from HCFA and in fact failed your standards.

Ms. O'KANE. That they were federally qualified. I do not know if they got flying colors.

Chairman THOMAS. The way we operate, if they meet the standards, that is it?

Ms. O'KANE. Yes, I think so. I do not think there are gradations, but I am not that familiar with the Federal qualification process.

I do want to make the point that we set our standards high. We did try to make them stretch standards, so there is a different philosophy about setting not a floor, but this is considered a good health plan if it is accredited by NCQA.

Chairman THOMAS. The bottom line is that if we turn to the private sector, we are probably going to find a better quality product because the standards are higher in the private sector.

Thank you very much.

Chairman BILIRAKIS. I thank the gentleman.

Dr. Ganske, would you like to inquire?

Mr. GANSKE. Thank you, Mr. Chairman.

Ms. O'Kane, can you delineate a few of the patient protections that you think would be important, as we look at Medicare managed care plans?

Ms. O'KANE. I think it is important that the complaint and grievance system work very effectively. I think it is important that there be an effective process for credentialling the physicians in the health plan. I think it is important that the utilization management practices of the health plan are based on current medical knowledge, that there are appeals mechanisms for physicians, that patients also have the right to appeal in the case where there is a denial.

Mr. GANSKE. Do you have any specific ideas in terms of how you would set up an appeals mechanism that would help meet insurer due process for both patients and providers?

Ms. O'KANE. We have a grievance system, a set of grievance system standards in our member rights and responsibilities statement which I will be happy to submit for the record. Basically, we want to see that there has been effective resolution of the problem in a timely manner, that the plan studies what is causing a lot of the complaints and grievances and goes back and corrects root causes,

and so forth. So we are looking for an effective process that solves individual problems, but also that goes back and is addressed at the system level.

I was really talking about the utilization management. If a plan were to say a certain medical service was inappropriate and the physician disagreed that it was inappropriate, our plans have to have an appeals mechanism for the physician where that decision can be reviewed.

[The following was subsequently received:]

## MEMBERS' RIGHTS AND RESPONSIBILITIES

*Note: A managed care organization may delegate complaint and grievance handling, and monitoring and evaluation of member satisfaction to another entity. NCQA may perform an on-site review of the delegated entity and will consider the delegated activities in evaluating the MCO's performance on Members' Rights and Responsibilities Standards 4.0 and 8.0. In addition, NCQA will perform a review of the MCO's oversight of delegation on Members' Rights and Responsibilities Standard 9.0. The MCO is accountable for ensuring that the delegated activities are in compliance with NCQA Standards.*

**RR 1.0 The organization demonstrates a commitment to treating members in a manner that respects their rights.**

**RR 1.1 At a minimum, the organization has a written policy that recognizes the following rights of members to:**

**RR 1.1.1 voice grievances about the managed care organization or care provided;**

**RR 1.1.2 be provided with information about the managed care organization, its services, the practitioners providing care, and members' rights and responsibilities;**

**RR 1.1.3 participate in decision making regarding their health care; and**

*1996 Clarification:* RR 1.1.3 prohibits restrictions on the clinical dialogue between practitioner and patient.

**RR 1.1.4 be treated with respect and recognition of their dignity and need for privacy.**

The MCO should have a written, officially adopted members' rights policy that covers the points above.

**DOCUMENT REVIEW**

| *Document* | *What To Look For* |
|---|---|
| Member Rights Policy for MCO and Delegated Entities | Review the policy statements and determine if the policy covers all of the points listed above. |

| *Interview the...* | *Discussion Points...* |
|---|---|
| Chief Medical Officer | How does the MCO ensure that its agreements with practitioners, and delegates' agreements with practitioners, do not limit clinical dialogue between practitioners and patients? |

**NARRATIVE** Complete the table in the *Data Collection Tools* for RR 1.0, and comment on any items not covered or limitations on rights statements.

**RR 2.0 The managed care organization has a written policy that addresses the members' responsibility for cooperating with those providing health care services.**

**RR 2.1 The written policy addresses the members' responsibility for:**

**RR 2.1.1 providing, to the extent possible, information professional staff need in order to care for the member; and**

**RR 2.1.2 following instructions and guidelines given by those providing health care services.**

The MCO should have a written, officially adopted members' responsibility policy that covers the points above.

**DOCUMENT REVIEW**

| *Document* | *What To Look For* |
|---|---|
| Member Responsibilities Policy | Review the policy statements and determine if the policy covers all of the points listed above. |

**NARRATIVE** Complete the table in the *Data Collection Tools* on RR 2.0 and comment on any deficiencies in the statement of responsibilities.

RR 3.0 **The managed care organization provides a copy of the organization's policies on members' rights and responsibilities to all participating providers and directly to members.**

The MCO should provide its policies on members' rights and responsibilities to all participating providers and all members. The provider distribution can be done as part of an initial mailing when the provider contracts with the MCO, or it can be incorporated into a provider handbook, as long as all providers receive it. The MCO should also give a copy of the statement of members' rights and responsibilities to all members. This can be done by incorporating the statement into a member services handbook that is sent to each subscriber or by sending a separate statement to all subscribers at the time of enrollment. Additionally, the MCO should have a mechanism for notifying members of updates to the policy as they occur.

DOCUMENT REVIEW

| *Document* | *What To Look For* |
|---|---|
| Statement Sent to Providers | Does the document state members' rights and responsibilities as shown in the adopted policies?<br>Is the document clearly written, unambiguous, and understandable? |
| Provider Manual | Same as for the Statement Sent to Providers, above. |
| Statement Sent to Members | Same as for Statement Sent to Providers, above. |
| Member Services Handbook | Same as Statement Sent to Providers, above. |

INTERVIEWS

| *Interview the...* | *Discussion Points* |
|---|---|
| Key Member Services Staff | Review with the staff how and when the MCO sends the members' rights and responsibilities statement to existing and new members. |
| Key Provider Relations Staff | Review with the staff how and when the MCO sends the members' rights and responsibilities statement to existing and new providers. |

NARRATIVE Describe how and when the MCO sends the statement of member rights and responsibilities to existing and new providers and to existing and new members, and any differences between the member statement and the provider statement.

**RR 4.0 The managed care organization has a timely and organized system(s) for resolving members' complaints and formal grievances. (Surveyors will consider delegated as well as nondelegated activity.)**

**RR 4.1 The system(s) includes:**

**RR 4.1.1 Procedures for registering and responding to complaints and grievances in a timely fashion;**

**RR 4.1.1.1 The managed care organization establishes and monitors standards for timeliness.**

**RR 4.1.2 Documentation of the substance of complaints, grievances and actions taken;**

**RR 4.1.3 Procedures to ensure a resolution of the complaint or grievance;**

**RR 4.1.4 Aggregation and analysis of complaint and grievance data and use of the data for QI; and**

**RR 4.1.5 An appeal process for grievances that includes at least the following:**

**RR 4.1.5.1 The member has a right to a review by a grievance panel;**

**RR 4.1.5.2 The member has a right to a second review with different individuals;**

**RR 4.1.5.3 At least one of the levels of review permits the member to appear before the panel; and**

**RR 4.1.5.4** **There is an expedited procedure for emergency cases.**

The formal complaint and grievance system should be designed to handle individual complaints and grievances in a timely fashion. The process should include all of the steps listed above to ensure an appropriate resolution. Having appropriate procedures to ensure resolution means that: 1) the member's issue stated in the complaint or grievance is addressed directly, 2) the MCO's response is appropriate to the seriousness of the complaint in the surveyor's judgment, and 3) any complaints that potentially relate to quality of care are referred to a clinical person for review. The process should also provide summarized information so that trends and problems can be identified and resolved through the QI process.

**DOCUMENT REVIEW**

| *Document* | *What To Look For* |
|---|---|
| Complaint and Grievance Policy and Procedures<br><br>*(May include member services instructions or standard operating procedures)* | Are all of the process requirements listed in RR 4.1.5 addressed?<br><br>Are the maximum time frames appropriate for the submission and resolution of complaints and grievances?<br><br>Is there a system for monitoring the complaint and grievance process to assure that time frames are met?<br><br>Is there a procedure to resolve each problem for the member and for the system, if appropriate, e.g., are complaints about providers investigated?<br><br>Is the procedure for resolutions, including clinical review, appropriate?<br><br>Are complaints and grievances controlled through a central file?<br><br>Is there a process of recording and categorizing complaints and grievances by type and provider so that the MCO can identify trends? Are complaint and grievance reports produced periodically and reviewed, as appropriate, by the QI Committee?<br><br>Do the procedures include informing the member of his or her right to appeal during each step of the complaint and grievance process? |
| Evaluation of 10 Complaint and Grievance Files<br><br>*(May be computerized)* | **Randomly select complaint and grievance files from the resolved complaint and grievance log. Assess the files on the "Evaluation of Complaint and Grievance Handling" worksheet.**<br><br>Does the MCO adequately document each complaint?<br><br>Were the grievance policies and procedures followed?<br><br>Were the time frames met?<br><br>Did the MCO respond to the substance of the complaint?<br><br>Were all complaints and grievances that had a possible medical component reviewed by a clinician?<br><br>Was the extent of the MCO's response commensurate with the seriousness of the complaint?<br><br>Was the member informed of the resolution of the complaint and of his/her rights of appeal? |

INTERVIEWS

| *Interview the...* | *Discussion Points* |
|---|---|
| Staff Responsible for Complaints and Grievances | Review the complaint and grievance policies and procedures, complaint and grievance files, and complaint and grievance reports with the staff.<br>• Identify any problems with the grievance policies and procedures;<br>• Identify any case files which show inadequacy in any area, including problems with meeting the time frames or resolving the complaints;<br>• Discuss how the complaint and grievance reports are used by staff to identify and monitor trends. |

**NARRATIVE** Complete the Complaint and Grievance Review Worksheet. Under each appropriate substandard, state (1) whether the procedures meet the substandard, and (2) the percent of cases reviewed that met the substandard.

*Note: Surveyors will consider delegated as well as nondelegated activities. Note any findings that are different for delegated entities.*

**RR 5.0 The managed care organization informs members about services provided, access to services, charges, and scheduling.**

**RR 5.1 Members are provided a written statement that includes information on the following:**

**RR 5.1.1 The managed care organization's policy on referrals for specialty care;**

**RR 5.1.2 Provisions for after-hours and emergency coverage;**

**† RR 5.1.2.1 the managed care organization's policy on when members should seek direct access to emergency care and/or utilize 911 services.**

**RR 5.1.3 Benefits and services included and excluded from membership and how to obtain them. This includes a description of:**

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† Note: Standard 5.1.2.1 is a new Standard and is being monitored. The substandard was added to address the issue of providing members with information and instructions on how, and under what circumstances, members should seek direct (i.e., without pre-authorization) access to emergency care and/or 911 services.

**RR 5.1.3.1** **any special benefit provisions (e.g., payment, higher deductibles, rejection of claims) that may apply to services obtained outside the system; and**

**RR 5.1.3.2** **the procedures for obtaining out-of-area coverage.**

**RR 5.1.4** **Charges to members, if applicable, including:**

**RR 5.1.4.1** **policy on payment of charges; and**

**RR 5.1.4.2** **copayments and fees for which the member is responsible;**

**RR 5.1.5** **Procedures for notifying those members affected by:**

**RR 5.1.5.1** **termination or change in any benefits;**

**RR 5.1.5.2** **termination of any services; or**

**RR 5.1.5.3** **the termination of any service delivery office/site.**

**RR 5.1.6** **Procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;**

**RR 5.1.7** **Procedures for changing practitioners;**

**RR 5.1.8** **Procedures for disenrollment of nongroup subscribers; and**

**RR 5.1.9** **Procedures for voicing complaints and/or grievances, and for recommending changes in policies and services.**

If the NCQA review covers more than one product and the MCO uses different member materials for its different products, check the materials for each product. These different products may include HMOs, point-of-service plans (POS), preferred provider organizations (PPOs), Medicaid plans, and Medicare plans.

For most MCOs, the information listed above is included in one or more of the following documents:

- member handbook;
- identification card;
- benefits summaries;
- participating provider handbooks;
- member newsletters.

If the information is presented in the member newsletter, the MCO should also include the information in other documents available to new members. Legal documents such as the Certificate of Coverage are generally not adequate vehicles for communicating important information to members.

**DOCUMENT REVIEW**

| *Document* | *What To Look For* |
|---|---|
| Member Literature | Are all of the points listed above covered in logical places in clear, understandable language in the documents? |

**INTERVIEWS**

| *Interview the...* | *Discussion Points* |
|---|---|
| Key Member Services Staff | Review any deficiencies in the documents with staff. If information is presented in member newsletters or through mailings to members, request and review copies of applicable newsletters and mailings. Ask staff how this information is provided to new members. |



**RR 5.2 The managed care organization takes steps to ensure that services offered are accessible to members:**

**RR 5.2.1 The points of access to primary care, specialty care, and hospital services are identified for members.**

**RR 5.2.2 Members are informed about how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.**

The member services handbook usually provides a general description of the MCO's health care delivery system. The provider directory usually includes lists of providers (primary care, specialty, and inpatient).

**DOCUMENT REVIEW**

| *Document* | *What To Look For* |
|---|---|
| Member Services Handbook, Member ID Card | Is there a clear, understandable description of how to obtain services during regular hours of operation, how to obtain urgent and after-hours care, and how to obtain emergency care?<br><br>Is there a clear description of how the member can obtain the names and professional qualifications of primary and specialty providers? |
| Provider Directory | Does the provider directory list the names, addresses, and telephone numbers of providers, including primary care providers, specialty care providers, and inpatient providers?<br><br>Is there a clear description of how the member can obtain the names and professional qualifications of primary and specialty providers?<br><br>If the MCO uses a primary care gatekeeper system, does the provider directory clearly explain that specialists should be accessed through the primary care physician? Does it explain exceptions such as self-referrals for behavioral healthcare and well-woman visits if the MCO provides for exceptions?<br><br>If a behavioral health gatekeeper system is used, does the provider directory clearly explain how to access behavioral health services? |

**INTERVIEWS**

| *Interview the...* | *Discussion Points* |
|---|---|
| Key Member Services Staff | Review any problems with the MCO's materials for members. |

**NARRATIVE** Complete the table in the *Data Collection Tools* for RR 5.0, showing a source for each item. Note any missing items in materials for any product.

**RR 6.0 Member information is comprehensible and well-designed.**

**RR 6.1 Member information is written in language that is readable, easily understood, and consumer tested, if possible.**

**RR 6.2 Member information is available, as needed, in the language(s) of the major population groups served.**

Member information should be designed for use by a broad audience. Materials should be visually attractive and the type should be easily readable. If the MCO serves major population groups whose principal spoken and written languages are other than English, or for which literacy is at a lower level, the MCO should be able to provide member services materials in alternative forms.

**DOCUMENT REVIEW**

| *Document* | *What To Look For* |
|---|---|
| All the Materials Reviewed under RR 5.0 | Do the materials show elements of readable design, including easily readable typeface, frequent headings, and short, simple explanations?<br>Are materials available in the languages that the principal populations read? |

**INTERVIEWS**

| *Interview the...* | *Discussion Points* |
|---|---|
| Key Member Services Staff | How were the documents designed? Was any pre-testing done with representative members? What was the result?<br>What is the readability level of each document?<br>How has the MCO determined what percentage of its members speak other languages?<br>What percentage of the MCO's population primarily speak languages other than English? |

**NARRATIVE** Describe the readability of the materials and the languages in which materials are available. Attach copies of any documents which contain problems.

**RR 7.0 The managed care organization acts to ensure that the confidentiality of specified patient information and records is protected.**

**RR 7.1 The organization has written confidentiality policies and procedures.**

**RR 7.2** **The managed care organization ensures that patient care offices/sites have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information to persons inside and outside the managed care organization who should not have access to such information.**

**RR 7.3** **Patients are afforded the opportunity to approve or refuse the release of identifiable personal information by the managed care organization, except when such release is required by law.**

The extent of patient policies and procedures on confidentiality will vary according to the delivery model type. Staff and group-model MCOs require more extensive confidentiality policies and procedures because they maintain original medical records and have more employees who are directly involved in the establishment and maintenance of the records than some other models. In all models, there should be policies and procedures about confidentiality that apply to claims processing staff, UM and case management staff, and QI staff. (Note: "Staff" includes participating practitioners who serve on committees.) Policies should address:

- maintenance of confidentiality of information within the organization;
- protection of medical record information (both original information and documentation used for UM and case management);
- protection of claim information;
- release of information; and
    - at the request of the member
    - in response to legal requests for information
- orientation of employees to confidentiality policies and procedures.

The MCO should also require that all contracted providers, including primary care physicians' offices, have appropriate policies and procedures to preserve patient confidentiality. The MCO should assess the adequacy of the PCP offices' policies and procedures during its primary care physician site visit. (See Credentialing Standard 8.0.)

DOCUMENT REVIEW

| Document | What To Look For |
|---|---|
| Patient Confidentiality Policies and Procedures | Do the policies and procedures address all of the above issues? |
| Primary Care Physician Site Visit Protocol | Does the protocol address PCP office confidentiality policies and procedures? |
| Credentialing Files | Do the completed site visit forms indicate that provider confidentiality policies were reviewed?<br>Do the completed forms indicate that the physicians' offices have appropriate confidentiality policies and procedures? |

**NARRATIVE** Complete the table in the *Data Collection Tools* for RR 7.0 and comment on any procedures that are deficient.



**RR 8.0 The organization assesses and enhances member satisfaction with its services. (Surveyors will consider delegated as well as nondelegated activity.) The managed care organization:**

**RR 8.1 Periodically assesses at least a sample of:**

**RR 8.1.1 patient complaints;**

**RR 8.1.2 requests to change practitioners and/or facilities; and**

**RR 8.1.3 disenrollments by members.**

**RR 8.2 Conducts periodic surveys of member satisfaction with the managed care organization's services;**

**RR 8.3 Identifies sources of dissatisfaction;**

**RR 8.4 Addresses sources of dissatisfaction; and**

The MCO should have a systematic method of accomplishing the following;

- assessing member satisfaction by routinely categorizing and analyzing:

  - patient complaints and grievances,

  - requests to change primary care providers, and

  - disenrollments.

  Depending on the MCO's organizational structure, different organizational units may carry out these activities. For example, Member Services may summarize and analyze complaints and grievances; the enrollment staff may summarize and analyze requests to change primary care sites; and the Marketing Department may summarize and analyze disenrollments. Alternatively, the MCO's provider relations or QI staff may have responsibilities for some or all of these activities.

- conducting periodic surveys of member satisfaction with the MCO's services, including the provision of health care services. The survey results should be presented to the QI Committee;
- using the tools listed above to identify sources of dissatisfaction; and
- implementing actions to improve member satisfaction and measuring the effectiveness of corrective actions.



DOCUMENT REVIEW

| *Document* | *What To Look For* |
|---|---|
| QI Studies and Reports: survey analysis, complaint and grievance reports, PCP change reports. | Is there evidence that the activities listed above have been carried out?<br>What areas of dissatisfaction have been identified?<br>What actions for improvement have been taken? |

**INTERVIEWS**

| *Interview the...* | *Discussion Points* |
|---|---|
| Key Member Services Staff | Review any complaint and grievance reports, provider transfer reports, disenrollment surveys, and member satisfaction surveys.<br>• How do staff analyze the data?<br>• Who in management receives the information?<br>• What QI Committee or subcommittee receives the information?<br>• What sources of dissatisfaction have you identified? How has the MCO addressed them? |
| CEO | What information on complaint and grievance reports, provider transfer reports, disenrollment surveys, and member satisfaction surveys do you receive?<br>How do you use this information?<br>What sources of dissatisfaction have you identified? How has the MCO addressed them? |
| Key Provider Relations Staff | Same as for CEO, above.<br>Does the MCO aggregate and analyze complaints and grievances and satisfaction data on a practitioner-specific basis? How is this information used? |
| QI Program Staff | Same as for CEO, above. |

**NARRATIVE** Describe the mechanisms by which the MCO assesses member complaints and grievances, primary care transfers, and disenrollments. Briefly describe and critique any member satisfaction surveys. Describe the sources of dissatisfaction that have been identified, and evaluate how the MCO has addressed those problems. If the MCO has taken action to improve an area, and then re-measured and demonstrated improvement, include that information in QI 10.1 and QI 11.2.

**RR 8.5 Informs practitioners and providers of assessment results.**

The MCO should provide reports of member satisfaction to practitioners and providers. If applicable, practitioner/provider-specific results should be reported directly to the affected individuals or institutions. The MCO should communicate its overall findings to the practitioner/provider population in general.

**DOCUMENT REVIEW**

| *Document* | *What To Look For* |
|---|---|
| Individual Surveys and Studies | Are results presented clearly?<br>Is there evidence that results were shared with the appropriate practitioners/providers?<br>Were providers given an opportunity for feedback? |
| Provider Communications | Are results of the MCO's patient satisfaction studies and surveys presented clearly? |

**INTERVIEWS**

| *Interview the...* | *Discussion Points* |
|---|---|
| Key QI Program Staff and Medical Director | Review how the MCO shares the results of member satisfaction studies and surveys with practitioners/providers. |
| Primary Care and Specialty Physicians | Are they aware of the MCO's activities to measure member satisfaction?<br>Have they ever been involved in a study or survey. If yes, did the MCO send the physician the results of the survey?<br>Has the MCO ever communicated the overall results of member satisfaction activities?<br>Are the primary care and specialty physicians aware of any activities that the MCO has undertaken to improve member satisfaction? |

**NARRATIVE** Describe how the MCO keeps practitioners and providers informed of member satisfaction issues.

*Note: Surveyors will consider delegated as well as nondelegated activities. Note any findings that are different for delegated entities.*

**RR 9.0 If the managed care organization delegates any member services activities (e.g., complaints and grievances, processes, and member surveys), to contractors, there is evidence of oversight of the contracted activity.**

Delegation is a formal process by which an MCO gives a contractor the authority to perform member services functions on its behalf. Although an MCO can delegate the authority to perform member services activities, it should retain oversight to ensure that the function is performed appropriately Oversight is defined as the monitoring of a set of activities in order to assess performance. The MCO is accountable for ensuring that the delegated activities are in compliance with NCQA Standards.

**RR 9.1 There is a written description of:**

**RR 9.1.1 the delegated activities;**

**RR 9.1.2 the delegate's accountability for these activities;**

**RR 9.1.3 the frequency of reporting complaints and grievances, and member survey data, to the managed care organization; and**

**RR 9.1.4 the process by which the delegation will be evaluated.**

There should be a mutually agreed upon description of the delegation of any member services activities to contractors. This could be included in the provider contract, a memorandum of understanding, and/or the MCO's provider policy and procedure manuals. The description should encompass the points listed above.

**RR 9.2 There is evidence of:**

**RR 9.2.1 approval of the delegate's member services program; and**

**RR 9.2.2 evaluation of regular specified reports.**

The managed care organization should:

- approve the delegated entity's method of handling the full scope of the delegated activities;
- obtain regular reports from the delegated entity that describe performance on the delegated activities, including complaints and grievances and member survey data, as applicable, and planned improvement actions; and
- evaluate the delegated entity's performance against the applicable NCQA Standards.

**DOCUMENT REVIEW**

| *Document* | *What To Look For* |
|---|---|
| Agreement or letter with delegated entity | Are all of the points in 9.1 covered in the written agreement between the managed care organization and the delegated entity?<br><br>If complaint handling is delegated, is there a clear description of the member's appeal rights for complaints and grievances?<br><br>Is the document signed by both the MCO and the delegated entity? |
| Delegated Entity Reports | If complaint handling is delegated, does the delegated entity routinely report aggregated complaint and grievance information? Does the entity report its planned follow-up of problems identified through the complaint and grievance process, and the results of follow-up activities?<br><br>If satisfaction surveying is delegated, does the delegated entity routinely report member satisfaction information? Does the entity report planned follow-up of problems identified through member surveys, and the results of follow-up activities? |

**INTERVIEWS**

| *Interview the...* | *Discussion Points* |
|---|---|
| Key Member Services Staff | Review the scope of the contract with the delegated entity.<br><br>Review how the MCO monitors the delegated entity's activities. Confirm the frequency with which such monitoring takes place.<br><br>Review how the MCO determines whether the delegated entity's activities meet NCQA Standards.<br><br>Review the provider's and member's rights to appeal decisions to the delegated entity and to the MCO.<br><br>Review how the MCO monitors member satisfaction with the delegated entity's services.<br><br>Review how the MCO monitors the effectiveness of and satisfaction with the delegated entity's staff. |

**NARRATIVE** Describe the scope of the delegation of member services. Describe how the MCO monitors the delegated entity's performance, any problems identified, and any actions taken to improve.

Mr. GANSKE. Frequently, I suspect disputes arise because enrollees will claim that they did not fully understand the full provisions of a plan or the restrictions of a plan. Do you think it will be important for us to address that issue as we talk about expanded managed care?

Ms. O'KANE. Yes, I do. In our standards, we have standards about the clarity of the information. We actually look through their materials to make sure they are clearly explaining how the system works. We have done a lot of focus group work, and this is an area where patients consistently tell us that they did not understand how the plan worked, and where I have suggested, particularly with the Medicare population, that additional care should be taken to have information brokers, perhaps some senior organizations, that could help people really understand how the system works before they choose to enroll in the system.

Mr. GANSKE. Thank you very much. I yield back my time.

Chairman BILIRAKIS. I thank the gentleman.

I am going to excuse this panel at this point. Thank you so very much. You cannot imagine how helpful you have been.

Ms. O'KANE. Thank you very much.

Chairman THOMAS [presiding]. The next panel, I would ask you to come forward, consists of Dr. Bristow, president, American Medical Association; Mr. Sprenger, chair-elect, Board of Trustees, American Hospital Association; Mr. Walworth, president, Health Alliance Plan of Michigan; and Ms. Lehnhard, senior vice president, Policy and Representation, Blue Cross & Blue Shield Association.

I will indicate to all of you that if you have any written testimony, it will be made a part of the record and you may proceed to inform the joint Subcommittees in any manner you see fit.

Dr. Bristow, by your attendance today—and I have not been keeping count—you may now be only two behind the American Association of Retired Persons. They declined to come today, so you have a chance down the stretch to at least break even with certain senior organizations. It is a pleasure to have you with us and to underscore the fact that you are one of the groups that have taken us seriously in saying, look, folks, this is not easy, take a look at it and give us your ideas. So we are pleased to have all of you with us, and we might as well start with Dr. Bristow.

## STATEMENT OF LONNIE R. BRISTOW, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Dr. BRISTOW. Thank you very much, Chairman Thomas and Members of the Subcommittees. My name is Lonnie R. Bristow, M.D. I am a practicing internist from San Pablo, California, and president of AMA, the American Medical Association.

Today I am pleased to offer our views and suggestions on the most important questions this Congress will face in reforming Medicare, that is what should be the appropriate standards required to protect our Medicare patients and who should be responsible for developing these standards. While choice is the heart of our proposal, the AMA believes that health plan standards and patient protections are its backbone.

As we see it, there are two challenges that the transformation will present: First, patients must be assured that the quality of

care they have come to expect will continue. To meet this objective, standards must be put in place in both the public and private sectors. Second, the innovations in quality and efficiency occurring throughout the country must be identified, evaluated, and then integrated into Medicare plans. Now, this will allow a transformed Medicare system to provide the cost savings needed while improving the quality of care provided.

As Medicare beneficiaries are offered more choices, they must be given the appropriate tools and information to make the choices meaningful. To this end, the AMA urges Congress to include the following five principles in Medicare reform which have enjoyed bipartisan support:

Disclose to patients plan information on their rights and responsibilities; appropriate professional involvement in medical policy matters; disclose utilization review plan policies and procedures; patients must have reasonable opportunity for choice of physicians, delivery systems and plans; and patients must have reasonable access to physicians and specialists.

In addition, there are legitimate concerns regarding market segmentation and practices designed to attract healthy enrollees. Plans should benefit from competition and their ability to constructively improve the health care delivery process, but they should not be allowed to seek out and cover only relatively healthy individuals, while avoiding the sicker, more costly elderly. An insurance company should be prohibited from offering physicians and physician groups inducements to reduce or limit medically necessary services provided to patients.

In order to allow the market to operate, however, there should be flexibility in how these principles are achieved. For example, accreditation by voluntary private sector bodies should be recognized as an alternative to direct government regulation. Also, the patient-physician relationship must be safeguarded by allowing physicians to seek reasonable participation in plans. They should also have the ability to review the reasons why participation would not be continued.

To guarantee fairness, enrollees and providers should have access to a disputes resolution system where differences occur with administration policy. Physicians have a duty to ensure that patients receive necessary and appropriate care. It is therefore reasonable that physicians should be allowed to be involved in the development of medical policies of a plan. We also believe that quality management systems and utilization review programs should be based on sound scientific and medical information. Costs cannot be allowed to drive quality.

To put muscle on the backbone of Medicare standards, we are proposing the creation of a "partnership for health care value," to give practitioners and plans the best clinical judgments possible. This congressionally chartered corporation would be governed and funded by a broad range of private and public health care entities. The work of the partnership is detailed in the AMA's transformation proposal previously submitted to you.

Members of the Subcommittee, choice demands options, and many physicians want the opportunity to order their own integrated delivery systems. They believe they could compete against

the large corporate health care plans and powerful insurance companies, if given the chance. Many multispecialty group practices already do so; for example, the Cleveland Clinic, Oschner Clinic, and the Mayo Clinic.

The second obstacle in their way, however, relates to antitrust concerns. The Department of Justice and the FTC have promulgated a very narrow set of guidelines. Unlike insurers and other nonproviders, it is still considered illegal for physicians to form certain kinds of networks and plans such as PPOs. Additional legislative action is needed to clarify the antitrust laws in this area.

In closing, the AMA's proposal is based on the idea of a competitive market-driven system as the best option for the future of the Medicare Program. It offers more choice and the greatest value to senior citizens and the disabled. Patients will have the opportunity to make wise prospective choices of physicians and financing mechanisms, but Congress must ensure that adequate standards are in place to protect them.

Thank you for the opportunity to present our views, and I welcome your questions.

[The prepared statement and attachments follow:]

Statement

of the

American Medical Association

to the

Subcommittee on Health
Committee on Ways and Means

and the

Subcommittee on Health and Environment
Committee on Commerce

U.S. House of Representatives

**RE: STANDARDS FOR HEALTH PLANS PROVIDING COVERAGE IN THE MEDICARE PROGRAM**

Presented by Lonnie R. Bristow, MD

July 27, 1995

Mr. Chairman Thomas, Mr. Chairman Bilirakis and Members of the Subcommittees, My name is Lonnie R. Bristow, MD. I am a practicing internist from San Pablo, California, and President of the American Medical Association (AMA). As you know, I have recently had the opportunity to testify before both of your Subcommittees regarding the AMA's views on the factors precipitating Medicare's current crisis as well as the AMA's proposal to transform Medicare. Today, I am pleased to offer our views and suggestions concerning what we believe is one of the most important questions Congress will face during this debate -- that is -- what are the appropriate standards required to protect our Medicare patients in an environment that is conducive to choice and who should be responsible for developing standards and protections.

As I mentioned in previous testimony, the heart of the AMA's proposal is based on a competitive market-driven system which offers more choice to senior citizens and the disabled without placing them at risk. Without again going into detail, these choices would range from remaining in the restructured Medicare program, to selecting from various competing health plans, including managed care plans, to investing in a Medical Savings Account (MSA) coupled with a catastrophic coverage. The government would pay the same amount regardless of the patient's choice.

The AMA believes that while choice is at the heart of our proposal, health plan standards and patient protections are its backbone. As we see it, there are two challenges that the transformation will present. The first is to adequately assure patients that the quality of the care they have come to expect can be maintained at a high-level, even in a market-driven system focused on costs. We believe that to successfully achieve this objective, standards must be put in place in both the public and private sectors.

The second challenge is ensuring that innovations in efficiency and quality occurring throughout the country can be identified, evaluated and then integrated into Medicare plans. In other words, Medicare beneficiaries, if given a choice must also be given the appropriate information to make these choices in an informed manner, and plans must be given the appropriate clinical information to improve quality and reduce costs.

The AMA maintains that as Medicare beneficiaries are offered more choices they must be provided with the appropriate tools to make these choices meaningful. The AMA urges that plans be guided by the following principles which enjoyed bipartisan support in the past Congress. In general, plans should:

- disclose to patients plan information, rights and responsibilities;
- provide for appropriate professional involvement in plan medical policy matters;
- disclose utilization review plan policies and procedures;
- provide reasonable opportunity for patient choice of plans and physicians; and
- provide reasonable access to physicians and specialists.

*DISCLOSURE*

More specifically, plans should disclose to patients information on plan costs, benefits, operations, performance, quality, incentives and requirements to potential and current enrollees. In selecting plans, individuals need information to understand how the plan operates, what they get in benefits, what they must do to ensure that services are covered, where and from whom they get services, and how plans compare on items such as quality indicators, patient satisfaction, cost control programs, and grievance procedures.

Furthermore, there are legitimate concerns regarding market segmentation and marketing practices designed to attract healthy enrollees. While plans should be allowed to benefit from competition and their ability to constructively improve the health care delivery process, they should not be allowed to seek out and cover only relatively healthy individuals while avoiding the sicker, more costly elderly. Marketing practices need to be evaluated as well and insurance companies should not be allowed to offer physicians and physician groups inducements to reduce or limit medically necessary services provided to patients. The AMA believes that there should be a minimum set of provisions that plans must meet and enrollment procedures that plans must comply with that are fair and avoid inappropriate market segmentation.

As a federally funded program it is important to assure that there be some minimum set of services that each plan provides with appropriate incentives for preventive services. Plans should have flexibility as to how they provide the services and should be able to enhance the benefit package in any way that meets customer and market needs. At the same time, plans also need to have arrangements so that enrollees can expect reasonable access to all medically necessary and appropriate care. In order to allow the market to operate, however, there should be several allowable alternatives in achieving these requirements. For example, to the greatest extent possible, accreditation by voluntary private sector bodies should be recognized instead of direct government regulation. Therefore, procedures should be put in place for recognition of private sector accreditation programs.

*DISCLOSURE OF PLAN POLICIES AND PROCEDURES*

In order to guarantee fairness and that necessary medical services are provided, procedures must be established that provide enrollees and providers with a system to resolve disputes within the plan. In cases where the grievance or dispute cannot be resolved within the plan, participants should be able to seek independent means to address the problems.

Due to the nature of the patient-physician relationship, physicians should be allowed to seek

participation in plans. Physicians should also have the ability to examine with the plan the reasons why participation would not be continued, for example, where involuntary termination occurs.

*APPROPRIATE PROFESSIONAL INVOLVEMENT*

We believe that it is the duty of physicians to ensure that their patients receive necessary and appropriate care regardless of the setting or method of payment in which that care is delivered. To make certain that physicians are able to meet this obligation, plans need to provide a process, such as a medical staff, for meaningful physician involvement in the development of medical policies of the plan, including drug formularies. It is also necessary for plans to have procedures and methods that assure that high quality care is provided, yet plans should also be given some degree of flexibility in order to achieve these standards and to encourage innovations in quality improvement and cost-effective care. In addition, the AMA believes it is well suited to develop a program for physician performance assessments.

*DISCLOSURE OF UTILIZATION REVIEW*

In plan quality management systems and utilization review programs, it is necessary that these programs operate to enhance patient care and be based on sound scientific and medical information. Cost alone cannot be allowed to drive quality. Those who are involved in final decisions should be knowledgeable and qualified in the area they are reviewing. Procedures need to be fair and prompt.

*ADMINISTRATIVE SIMPLIFICATION*

Accrediting bodies that now exist for managed care and other health benefit plans, such as the National Committee on Quality Assurance (NCQA), properly require that each plan have procedures regarding credential verification, inspections and other mechanisms to assure that the practitioners and the facilities within their programs are capable of delivering care and meeting plan quality and other standards. Unfortunately, when a physician or a medical group participates in more than one plan, there can be multiple inspections and other administrative requirements that serve the same purpose but provide no new information and increase costs and divert attention away from patient care. Therefore, to the greatest extent possible, uniform information requirements and inspection or certification procedures should be established to avoid duplication of efforts and increased costs. The federal government should foster this uniformity by providing grants to private sector organizations for the development of acceptable uniform standards, procedures and inspections. Provider credential verification should be made as easy as possible. To avoid duplication of efforts, a private verification service should be recognized in lieu of repeated validation of primary source data. Likewise, when a plan contracts with an Individual Practice Association (IPA) for the provision of physician services, it should delegate verification to the IPA.

With respect to federal regulations and administrative simplification, federal law currently requires an opportunity for public comment on proposed rules. This involvement takes place after the drafting has already occurred and in a context that is not conducive to give and take. Therefore, in areas where there will be continued federal regulation, the AMA recommends that a major emphasis be placed on using negotiated rulemaking procedures to improve the quality of needed regulations in the health care sector.

*PARTNERSHIP FOR HEALTH CARE VALUE*

Just as Medicare beneficiaries should be afforded the tools to make wise and informed choices, plans and practitioners should also be given the appropriate tools to make the best clinical judgments. Therefore, to put muscle on the backbone of the Medicare standards we are proposing, an unprecedented **"Partnership for Health Care Value,"** should be created. The Partnership could be a Congressionally chartered corporation similar to the National Academy of Sciences and the Institute of Medicine and would focus on private and public sector efforts devoted to practice guidelines development and organizing a structure to guide

development and dissemination of improvements in medical practice and health care delivery. The Partnership should be governed and funded by representatives from medical societies, hospital associations, insurers and national managed care companies, accrediting agencies, employers, consumer groups, and the federal agencies. It would act as a clearinghouse and marshall private sector resources devoted to the development and application of medical standards. These standards or practice guidelines would be used by both clinicians and health benefit plans as a basic protection for patients to assure that they receive state-of-the-art medical care. The work of the Partnership would include:

- Developing standards for outcomes measurement and reporting, including the content and format of electronic patient records, and guiding and coordinating efforts to gather outcomes data;
- Coordinating technology assessment and establishing standards for technology, dissemination and use;
- Establishing priorities for guideline development through analysis of variations in practice or important procedures;
- Creating guidelines for coordinating the development of, and disseminating practice parameters;
- Creating guidelines for the development of methodology for profiling and evaluating health care providers;
- Developing interventional tools and education programs to change practice patterns;
- Making recommendations about the content of basic benefits packages; and
- Evaluating health care spending and pinpointing areas needing study and corrections.

While it may come as a surprise to the uninitiated, it is a fact that current standards for treatment practices and outcomes vary considerably. The AMA believes that by creating the Partnership, both practitioners and plans may begin the arduous and comprehensive process of developing a common standard of medical care that can be measured, analyzed and evaluated.

*PHYSICIAN SPONSORED COORDINATED CARE ORGANIZATIONS*

The AMA recognizes the need to transform the Medicare system. The AMA also understands that many physicians want the opportunity to offer their own integrated delivery systems and believe they could compete against large corporate health care plans and powerful insurance companies, if given the chance. The benefits to the Medicare program would be lower costs and higher quality of care than in non-physician/provider health plans. For example, costs would be lower because contracting with a Physician Sponsored Coordinated Care Organization (PCCO) instead of an insurer could eliminate a layer of profit and overhead. Quality would be higher because physicians would have direct control over medical decision-making, and physicians are best qualified to strike the balance between conserving costs and meeting the needs of the patient.

There is already a substantial infrastructure of PCCOs. The ideal PCCO is physician directed, with vehicles for input from the physicians that deliver health care through the PCCO. They include large, multispecialty group practices such as the Permanente Medical Group, and, in more recent years, the Cleveland Clinic, Oschner Clinic, and the Mayo Clinic, academic medical centers, large "clinics without walls," and hospital systems that have partnered with physician networks. Many of these PCCOs include a full range of

providers and are capable of contracting to provide care for Medicare beneficiaries.

In addition, many physicians and other providers are interested in forming PCCOs. Physicians and hospitals are exploring ways to organize themselves so they can operate on a prepaid basis. There are almost no communities in the United States where physicians and other providers are not considering or actively forming a PCCO. If these explorations resulted in the formation of numerous new PCCOs, the public benefits would be substantial.

There are, however, obstacles to realizing the benefits of competitive PCCOs. One is a trend towards treating PCCOs that operate on a prepaid basis as insurance companies that are required under state law to register as insurers and comply with all applicable state regulations. Treating PCCOs as insurers does not make sense because, unlike the conventional insurer or HMO, a PCCO consists of the physicians and providers capable of delivering the product that it has contracted to provide on a prepaid basis. The PCCO does not have to contract with providers to deliver the care. Requiring the PCCO to comply with insurance regulations adds unnecessary costs to their operations. Instead, a PCCO should be likened to a self-insured plan in so far as a self-insured plan pays out its own benefits using its own resources and assets in conjunction with reinsurance as a guarantee against excess claims.

The second problem is legal obstacles to the formation of PCCOs. Physicians and other providers face substantial practical problems that must be solved in the formation of a PCCO. While they do have on hand the ability to provide the services, they lack the capital resources that insurance companies and national managed care organizations have, and they lack the management infrastructure. To make matters even more difficult, legal regulations simply bar the formation of certain kinds of PCCOs. Compliance with legal regulations adds substantial costs and time to the organizational effort. For example, although the Department of Justice and the Federal Trade Commission have promulgated a set of Guidelines, it is still considered illegal for physicians to form certain kinds of networks and plans. Insurers and other non-providers may organize networks and plans without the same legal barriers. Additional legislative action is necessary on issues such as single and multi-provider networks.

Current trends in health care delivery and finance require that physicians and other providers cooperate to form health care delivery networks that are (1) capable of providing comprehensive health care services in a coordinated fashion, and (2) capable of managing financial risk, such as capitation and fee withhold arrangements. However, our legal structure has not yet adjusted to the new economic conditions. Several sets of laws actually interfere with the ability of providers to develop health care delivery systems, including antitrust laws, bars on legitimate self-referral, fraud and abuse laws, the tax regulation of pension plans, laws regulating tax exempt entities, and others.

To prevent physician values from being submerged and lost as a contribution to the competitive system, the minimum accommodation needed today is clarification of the antitrust laws supporting the rights and abilities of physicians and other providers to jointly present their views on any matter to insurance plans on behalf of themselves and patients. These changes should be made with the clear recognition that they are appropriate as long as no boycott and price-fixing is involved.

*CONCLUSION*

The reforms we propose are a fundamental shift away from government control toward personal responsibility, individual choice and an invigorated Medicare marketplace. The AMA's proposal is based on the idea of a competitive market-driven system as the best option for the future of the Medicare program because it offers more choice with the greatest value to senior citizens and the disabled. We must give the patient both the opportunity and the responsibility to make wise prospective choices of physician and financing mechanism, with the reasonable opportunity to change either if they prove unsatisfactory. An effective health care marketplace is only achievable if we rid ourselves of the current program's distortions that have had the perverse effect of aggravating, rather than easing, the government's burden in keeping Medicare's promise. We do, however, recognize the need for appropriate patient protections and rules to assure that a competitive market place meets the programs goals and responsible. As long as Medicare insulates patients from the true cost of the services they are consuming, a competitive Medicare marketplace will never flourish and costs will continue to escalate. We have taken the liberty of including legislative specifications regarding reforms to facilitate the formation of PPCOs and the antitrust laws as well as a description of our Partnership for Health Care Value. We stand ready to work with you and your staffs on this important issue.

## LEGISLATIVE SPECIFICATIONS: REFORMS TO FACILITATE THE FORMATION OF PCCOs

*ANTITRUST REFORMS*

Risk Sharing

- The physician participants in a PCCO should engage in risk sharing, which includes, without limitation, the following:
  - when the PCCO agrees to provide services at a capitated rate;
  - when the PCCO creates significant financial incentives for its members as a group to achieve specified cost-containment goals, such as withholding from all members a substantial amount of the compensation due to them, with distribution of that amount to the members only if the cost-containment goals are met;
  - when the PCCO agrees to provide services for global fee packages; or
  - when most of the member physicians hold significant ownership or equity interests in the PCCO, where the capital contributed by the members is used to fund the operational costs of the PCCO such as administration, marketing, and computer-operated medical information, if the PCCO develops and operates comprehensive programs for utilization management and quality assurance that includes controls over the use of institutional, specialized, and ancillary medical services.

Size

- PCCOs may have exclusive physician panels that include up to 30% of the physicians in the market, in aggregate and by specialty.
- PCCOs may have nonexclusive physician panels that include at least 50% of the physicians in the market.
- PCCOs may have exclusive or nonexclusive panels larger

than those set forth above if the PCCO is not in violation of any federal law.

- Alternatively, no size limits are set on PCCOs, and they are evaluated on whether they intend to or in fact engage in anticompetitive conduct.

Payment Arrangements

- Physician members of a PCCO may jointly determine the terms of financial arrangements between the PCCO and the physicians, including the method and amounts by which the physicians will be paid. The physician members may also jointly determine the terms of financial arrangements between the PCCO and any purchaser of the products offered by the PCCO.

- The physicians participating in a nonexclusive PCCO may not agree to boycott any purchaser, and they may not agree to fix prices for physician services when contracting with purchasers other than through the PCCO.

New Product

- A PCCO will be considered to be offering an additional or "new" product in a market for the finance and delivery of health care if it offers one of the following:

  - A preferred provider organization which has the following characteristics:

    - Physicians and other providers on the PPO's "panel" of providers agree to discount their fees or charges for treatment of PPO beneficiaries.

    - The PPO gives its beneficiaries financial incentives to use the providers on its panel. Beneficiaries may use providers who are not on the panel, but if they do so they are personally liable for larger copayments than are required when they use panel providers.

- The PPO engages in utilization review and quality assurance to control costs and maintain quality.
- The PPO administers and pays claims.

Studies

- Adopt the recommendation of the Physician Payment Review Commission that the DOJ and FTC conduct studies of the market for health care delivery and finance and the structure and role of PCCOs in the market. One part of the study should be directed at market definition to provide better guidance about how to define the size of the market in which a PCCO is being formed or is operating.

*SELF REFERRAL*

- Physician members of a PCCO may make arrangements among themselves to coordinate the care of patients who are beneficiaries of contracts between the PCCO and a purchaser. This includes referring to facilities or providers in which the other providers have a financial interest. Safe harbors should be created in the existing self referral laws for this kind of coordination of care.

*FRAUD AND ABUSE*

- Provider members of a PCCO may purchase physician practices and other providers or engage in other kinds of financial arrangements with providers that remain independent but commit to becoming part of the network. Safe harbors should be created for this activity.

*PENSION PLANS*

- Tax regulations should be developed which permit the formation of PCCOs without requiring aggregation of pension plans that have been independently developed and funded. Aggregation may be permitted on a prospective basis when a PCCO becomes fully integrated.

*CERTIFICATE OF NEED LAWS*

- Medicare providers should be exempt from Certificate of Need laws.

*REGULATION OF TAX EXEMPT ENTITIES*

- Tax regulations should be developed that allow tax exempt hospitals and tax exempt clinics to purchase physician practices at fair market value without endangering their exempt status. Tax regulations should be developed that allow tax exempt hospitals to affiliate with PCCOs without losing their exempt status. Tax regulations should allow up to 50% of the governing board members of a tax exempt health care delivery system to be physicians.

*STATE INSURANCE REGULATION*

- The National Association of Insurance Commissioners is asked to develop model regulations for risk bearing PCCOs that are appropriate for the function performed by those entities as opposed to treating them as insurance companies. These model regulations would not contain onerous capitalization, reserve, and surplus or registration requirements.

## LEGISLATIVE SPECIFICATIONS: REFORMS TO CLARIFY THE ANTITRUST LAWS WITH REGARD TO JOINT DISCUSSION WITH PLANS

- Where physicians are unable to create effective competing plans their only avenue for making effective input into the increasingly concentrated delivery system/payer control is through joint presentation of their views and patient views about plan matters. The Court of Appeals for the Ninth Circuit recently held, " ...individual health care providers are entitled to take some joint action (short of price fixing or group boycott) to level the bargaining imbalance created by the plans and provide meaningful input....." (Alston v. United States).

  Alston demonstrates the need to correct the FTC's interpretation of the antitrust laws regarding physician involvement in the development of fees by a physician network or health plan. Antitrust officials must issue a clear statement that physicians are free to approach health purchasers and plans jointly in order to provide input on fees and other payment-related issues, as long as the physicians do not engage in a boycott or threat of boycott. An agency or trier of fact should not infer a boycott threat from the mere fact of discussions -- some express or implied threat of coercive conduct by the physicians must be made. Otherwise, health care providers will be deterred from engaging in useful and potentially procompetitive activities.

## PARTNERSHIP FOR HEALTH CARE VALUE

Structure The Partnership would be established as a Congressionally chartered corporation. Therefore, it would operate under the auspices of Congressional purpose and would have some direct involvement of the federal government, but would not be an agency or an instrumentality of the Executive or Legislative Branches. Both the National Academy of Sciences and the Institute of Medicine are such corporations. The NAS was chartered in statute in 1863 (36 USC 251 et.seq.). It is recommended that we seek such a Charter to establish the purpose of the Partnership in law while allowing for the operation of the activity in the private sector.

Purpose The purpose of the Partnership is to advance the science of medical practice and health care delivery through improvement in the development, recognition and dissemination, coordination and focusing the effort to develop medical standards to be used by clinician and health benefit plans as a basic protection for patients to assure that they receive state-of-the-art medical care. Dissemination of medical practice guidelines and health services research would be the major focus initially.

The work of the Partnership would be to develop a plan that would include priorities for:

- Developing standards for outcomes measurement and reporting, including the content and format of electronic patient records, and guiding and coordinating efforts to gather outcomes data.
- Developing standards for and coordinating effectiveness research and technology assessment.
- Coordinating technology assessment and establishing standards for technology, dissemination, dispersion and use.
- Establishing priorities for guideline development through analysis of variations in practice or important procedures.

- Creating guidelines for coordinating the development of, and disseminating practice parameters.
- Creating guidelines for the development of methodology for profiling and evaluating health care providers.
- Developing interventional tools and education programs to change practice patterns.
- Making recommendations about the content of basic benefits packages.
- Evaluating health care spending and pinpointing areas needing study and corrections.

Powers

The Partnership would be allowed to make it own organization , including the make-up and composition of the Board of Trustees, by-laws , rules and regulations, to hold property, to enter into contracts, to receive money, pursuant to grant, contract or contribution from public or private sources to carry out its purposes. The Partnership would the authorized and empowered to receive, by devise, request, donation,or otherwise, either real or personal property,and to hold the same absolutely or in trust and to invest, reinvest and manage the same in accordance with the provision of its constitution and to apply said property and the income arising therefrom to the objections of its creation and according to instruction of donors, contractors and grantors. The Partnership would exist until such time as it dissolved and/or its charter is revoked.

Incorporators

Original incorporators would include entities that are significant in the development and dissemination of new medical information represented by the Chief Executive Officers of:

The AMA;

An organization that represents those in the field of accrediting health care delivery systems, such as the National Committee for Quality Assurance (NCQA)

An organization representing health services research including outcomes assessment research and the development of practice guidelines;

An organization that represents those in the field of biomedical research;

The Secretary of Health and Human Services (covering AHCPR and HCFA); and

The Director of the National Institutes of Health.

The original incorporators or their successors can increase the number of and identify further additional incorporators.

The original incorporators shall establish an advisory committee that seeks representation from all involved in the health care delivery system including, but not limited to, providers, insurers, consumers, other payers, standard setting bodies and employers. This advisory committee shall meet on a regular basis to provide views to the Partnership on the practical implications and aspects of the Partnership's work. Organizations that should be involved include:

Organizations representing hospitals such as the American Hospital Association or the Federation of Health Systems;

Organizations representing health insurers and health care delivery systems such as the Health Insurance Association of American and the Blue Cross/Blue Shield Association;

Organizations that represent employers, both large and small, that provide health benefits to their employees;

Organizations that represents consumers of health care services;

Operation — The Partnership would be able to hire staff to assist in carrying out its functions. In addition, it would be able to contract with other organizations to provide staff for its functions and it would be able to contract with other organizations for the performance of various functions.

It is expected that the Partnership would have a relatively small staff, and would, instead, rely upon resources that the private sector or government agencies bring to it within the context of grants and contracts to conduct research or develop initiatives consistent with its purposes. The Partnership would focus on setting the methodologies for these activities, setting priorities for them, and in reviewing and approving of the work done by private sector organizations. For example, in the development of practice parameters, the Partnership would proceed by reviewing the efforts of various organizations to develop methodologies for the creation of parameters. These would include the attributes of practice parameters developed by the AMA\Medical Specialty Society Practice Parameters Partnership, the principles developed by the AHCPR, the principles developed by the Institute of Medicine, and by others. The Partnership would then reach a consensus on a single set of attributes or principles. Subsequently, the Partnership would review existing practice parameters against the principles that it develops. Sources of existing parameters include those listed in the compendium of practice parameters developed by the American Medical Association, those developed by the AHCPR, and others. Practice parameters which met the approval of the Partnership would then be adopted by it. Approved practice parameters would be forwarded to HCFA for use in the Medicare and Medicaid programs. HCFA would review and approve of them, and then put them through a public notice and comment process. Any problems discovered would then be referred back to the Partnership for resolution.

After completing this process, the Partnership would then set priorities for the development of practice guidelines. The priorities would be disseminated to the public. Organizations that had an interest in a topic would then inform the Partnership of their intent to form a practice parameter, and would provide the Partnership with a time table for development.

Similar procedures could be used for the other topical areas, such as the development of standards for the measurement and reporting of outcomes, for the performance of outcome studies, and others.

Funding Each of the original incorporators would contribute to the initial operation of the Partnership. Thereafter, the operations of the Partnership would be financed through grants, contracts and donations for services provided. The HHS Secretary and the Director of the National Institutes of Health would provide funding for the initial work plan and priority setting by the Partnership under Contract with the Partnership.

Rational A revolution is occurring in medicine which promises to substantially reduce costs while maintaining and enhancing quality. However, this revolution will not succeed unless a coordinated effort is made to develop the tools necessary for the revolution to take place. Medical societies, many other private sector organizations, and government agencies such as the Agency for Health Care Policy and Research are working at creating the tools necessary for the revolution. However, these efforts are fragmented and duplicative, and the tools needed are being developed at far too slow a pace.

The basis of the revolution is the information explosion in medicine and systems designed to manage information made possible by computer technology. The revolution involves:

- The reassessment of virtually all medical practice to determine the extent to which generally accepted clinical practices help patients. Much of medicine is

based on the experience of physicians and does not have a basis in scientific research. The object is to weed out generally accepted practices that cost money but do not result in a significant benefit to the patient. This reassessment is conducted by gathering together all information about a medical topic and synthesizing the best of it into practice parameters that can be used by physicians in clinical practice.

- This reassessment is supported by outcomes measurement and reporting, which involves the gathering of massive amounts of data about how well patients responded to medical treatment and analyzing that data. This kind of information gathering and analysis is now possible with computer technology.

- The continuous assessment and improvement of the quality of care actually delivered to patients by providers. This involves gathering outcomes data for the patients of a health care delivery system and individual physicians, and using that information to determine ways in which the cost and quality performance of the provider can be improved.

- Making information about the cost and quality performance of health care delivery systems available to the public. This information can then be used in the selection of health plans and providers.

There is a need for generally accepted and authoritative medical standards for use developing the tools necessary for the medical revolution, and there is a need to develop the tools themselves. At present, numerous entities are developing standards of some kind for one or more purposes. These include efforts to develop practice parameters, computer software designed to screen claims, protocols designed for physicians to follow as they treat patients, and other tools. However, the methods used to develop these tools and the meaning of vocabulary used within them is often not disclosed. Vendors of utilization control systems often refuse to disclose the medical standards used in their systems on the grounds that the information is proprietary. The result is a confusing array of materials that are difficult for potential users to understand, evaluate and use. Further, there is no way that the tools being developed can be used together in a coordinated fashion to maximize the benefits that can be achieved with modern information systems technology.

Chairman THOMAS. Thank you, Dr. Bristow.
Mr. Sprenger.

**STATEMENT OF GORDON SPRENGER, EXECUTIVE OFFICER, ALLINA HEALTH SYSTEM, MINNETONKA, MINNESOTA; ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC**

Mr. SPRENGER. Thank you, Congressmen Thomas and Bilirakis.

I am Gordon Sprenger, executive officer of the Allina Health System in Minnesota, and chairman-elect of the American Hospital Association. We include in our membership 5,000 hospitals, health systems and networks, and other providers of care, and we are pleased to present our thoughts to you today.

Chairman THOMAS. Mr. Sprenger, let me tell you that these microphones are very unidirectional and you need to be right in front of it, or we are going to miss some of your remarks.

Mr. SPRENGER. Mr. Chairman, the private sector has been opening all kinds of doors, as we have heard this morning, in search of innovative ways to make the health care system more effective and user-friendly. Medicare meanwhile has mostly remained on the outside looking in. We believe that it is time for Medicare to offer more choices to its beneficiaries.

Our main theme to you today is that options will be necessary, as you consider Medicare reform, and it is a process of change. It is not a light switch you can just turn on. It is transition we will be going through. Not one solution is going to fit all. Moving more toward risk-reward sharing will bring the kind of behavioral change in providers which we think we will need to foster in order to get some of the cost savings that we want out of the system.

Medicare beneficiaries who want to choose coordinated care, rather than fee-for-service coverage, today just have two choices, an HMO, health maintenance organization, or a CMP, competitive medical plan. These plans accept full risk for the coverage they provide and are very important elements in a restructured health care delivery system. But Medicare should look beyond full risk contracts, as we look at multiple options. It should also consider limited risk-sharing arrangements with locally based networks of care, what we will call provider-sponsored networks, and I will comment on why.

First, the definition, what is a PSN. PSNs are formal affiliations of health care providers organized and operated to provide health care services under contract with insurance companies, HMOs, or other health plan companies. These networks commonly take the form of hospital-physician organizations or independent practice associations and are often called integrated delivery systems. They exist today in many parts of the country.

Many PSNs have formed HMOs or have become partners with insurers to do so, but some have not become HMOs. Some serve populations that are too small or too sick to support the full risk of an HMO. Some are in States where it reportedly takes up to 2 years to get an HMO license, and others are in areas where Medicare's HMO payment is simply too low to provide adequate care. Frankly, we are taking care of these patients as providers already,

and what we are asking for is the opportunity to move them into coordinated care.

We agree that any entity delivering care to Medicare beneficiaries must meet high standards. The current regulatory thinking limits the ability of these PSNs to serve Medicare beneficiaries in a coordinated care context. We believe the Medicare Program should take full advantage of the health care innovations and efficiencies offered by these PSNs by Medicare joining them in risk-sharing arrangements. We need Congress to change laws to allow the PSNs to contract directly with Medicare.

The standards these plans should follow should include the same important consumer protection standards and safeguards found in the HMO requirements. But because we are talking about PSNs not taking all the risks of a full risk HMO, they should be regulated differently. This means eliminating the requirement for a State HMO license, if the PSN's contract contains appropriate risk limiting provisions.

The purpose of a Medicare HMO or CMP is to protect against unexpected illness or injury and similar insurance risks, but this role is played by Medicare in a partial risk arrangement. The required inclusion of risk sharing or limit is clear evidence of an intent to avoid asking the PSN to take on an insurance role. This is particularly true when coupled with the fact that the arrangement predominantly covers services provided directly by providers.

Also, solvency requirements for PSNs should acknowledge that they need to invest their capital in providing services, and not in creating cash reserves to pay claims.

By making these changes, Mr. Chairman, PSNs can be recognized for what they are, organizations of providers that do not take on the full risk of unexpected illness or injury that ensures care. They would still, however, be regulated.

In conclusion, allowing these networks to contract with Medicare on a limited risk basis we think opens doors for everyone involved. We need many options to go through this transition. Medicare and the network providers and beneficiaries themselves would be able to choose their local hospitals, physicians, and other practitioners who organize to provide benefits in a coordinated and efficient way. It is a choice we think the seniors deserve to have.

Thank you.

[The prepared statement follows:]

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**Statement**
**of the**
**American Hospital Association**
**before the**
**House Committee on Ways and Means, Subcommittee on Health**
**and the**
**House Committee on Commerce, Subcommittee on Health and Environment**
**Joint Hearing**
**on**
**Standards for Health Plans Providing Medicare Coverage**

**July 27, 1995**

I am Gordon Sprenger, executive officer of the Allina Health System in Minnetonka, Minnesota, and chairman-elect of the American Hospital Association's (AHA) Board of Trustees. AHA includes in its membership 5,000 hospitals, health systems, networks and other providers of care. I am pleased to testify today on their behalf.

In recent hearings before both of these subcommittees, AHA has made the case that the Medicare program needs to change. While the private sector has been opening all kinds of doors in search of innovative ways to make the health care system more efficient and user-friendly, Medicare has effectively remained on the outside looking in, stuck in the traditional, fee-for-service mindset. Last week we laid out a road map on Medicare restructuring that included increasing beneficiary incentives to choose coordinated care, eliminating barriers that discourage the creation of coordinated care networks by inhibiting provider cooperation, fixing the problems with how Medicare calculates capitated rates for risk contractors, and expanding the choices available for Medicare beneficiaries.

My testimony today will explain how Congress can open the door for Medicare and its beneficiaries to benefit from provider-sponsored, locally-based networks of care. AHA believes that any entity that takes on the task of delivering care to Medicare beneficiaries must meet high standards, and be held accountable for the quality of care it delivers. But we also believe that ill-suited regulation must not close the door on groups of providers that can offer efficient, high-quality care for Medicare and its beneficiaries.

<u>Making the most of provider-sponsored networks</u>
Moving Medicare to the future will require the thoughtful restructuring of the program itself. Restructuring must include offering Medicare beneficiaries the same coverage options enjoyed by people with private sector coverage.

It is therefore critical that, in an effort to broaden beneficiaries' options, Congress not limit its thinking to the current options -- health maintenance organizations (HMO) or competitive medical plans (CMP). While those options are important in a restructured market and need some modification to make them work better, we believe Medicare must look beyond full-risk contracts with HMOs and CMPs. It must stimulate the availability of more plan choices to create a dynamic local market by also considering risk-sharing arrangements with what we generically call provider-sponsored networks (PSNs).

Provider-sponsored networks are formal affiliations of health care providers -- such as physicians and hospitals -- organized and operated to provide health care services under contract with insurance companies, HMOs or other health plan companies. Some PSNs are known as physician-hospital organizations, under which physicians create a joint venture with

a hospital. That joint venture in turn contracts on behalf of its members with health plan companies to offer a variety of health care services.

Other PSNs may be more integrated -- that is, there may be greater economic or corporate ties among the participants. These PSNs are often called integrated delivery systems. In my state of Minnesota, for example, hospitals may directly acquire physician practices and employ the practitioners. Still other PSNs may be less integrated -- independent practice associations, for example, allow providers to jointly contract with health plan companies and offer reduced rates to patients that are members of a plan without formally merging their practices.

These arrangements have evolved into a variety of corporate and organizational structures that reflect local market conditions and regulatory constraints. But, PSNs have several things in common. Among them: They are initiated, financed and governed by health care providers; and they are formed to deliver health care services through contracts with health plan companies.

Provider-sponsored networks play an important and positive role in health care delivery, particularly in the delivery of coordinated health care. Health plan companies find that the expansion of coordinated care programs is facilitated by PSNs, because they:

- Offer an established network of providers.
- Promote provider accountability for quality by acting as a mechanism to simplify administration and implement clinical quality management programs.
- Reduce a health plan's administrative expenses by providing a single party through which to negotiate contract terms.

Many PSNs have formed HMOs, or have become partners with insurers to do so and, as a result, have been able to provide coordinated care choices for Medicare beneficiaries. But others have not become HMOs for several reasons. Some serve populations that are either too small or too sick to support the full risk of an HMO. Some are in states where it reportedly takes up to two years to get an HMO license. And others are in geographic areas where Medicare's HMO payment would be too low to provide adequate care. Current regulatory thinking could limit the ability of these organizations to serve Medicare beneficiaries.

We believe the Medicare program should not limit beneficiary choices of coordinated care programs by contracting only with plans in which an insurer or HMO acts as the intermediary. Medicare should take full advantage of the health care delivery innovations and efficiencies offered by PSNs by joining them in risk-sharing arrangements as well.

Under such arrangements, PSNs would be paid on a partial capitation basis, but the risk assumed by the PSN would be limited. Financial risk-sharing arrangements would not expose PSNs to full insurance risk for unexpected illness or injury, yet would still create incentives for providers to manage utilization and keep people healthy.

Medicare should limit financial risk-sharing arrangements to PSNs that contract for the full benefit package and directly provide substantially all of the services through their own affiliated providers. This type of risk-sharing arrangement has worked well in the private sector to help contain health care costs. Because PSNs would not be taking on all the insurance risk of a full-risk HMO, they should be regulated somewhat differently than insurers or HMOs. If a PSN wishes to assume full capitation, then it should comply with HMO regulations.

AHA's recommendations

We believe that true restructuring of the program means that Medicare should contract directly with provider-sponsored networks, just as we have supported that freedom for ERISA self-insured employer group health plans. The standards that these plans should follow should include the same important consumer protection safeguards found in HMO requirements, but a few key modifications are needed. These include:

The 50/50 government/private enrollees rule, which requires that no more than half of a plan's enrollees be Medicare or Medicaid beneficiaries, is no longer necessary, particularly in this context. This rule was adopted to safeguard the quality and accessibility of care for government beneficiaries, but there are now other, more direct mechanisms to ensure quality. This would allow PSNs, particularly those that serve rural and chronically ill patients (primarily people covered by Medicare and Medicaid), to participate in the program.

The minimum-5,000-enrollee threshold has impeded the development of coordinated care in smaller rural communities. As long as the PSN can demonstrate its ability to provide a full range of services in a coordinated fashion, this requirement is also unnecessary.

The requirement for a state HMO license should be eliminated if the PSN's contract contains appropriate risk-limiting provisions. The purpose of a Medicare HMO or CMP is to ensure protection against unexpected morbidity (illness or injury) and similar insurance-type risks. This "back-stop" role can just as easily be performed by the Medicare program as by an HMO or CMP without having to pay the HMO additional fees for those insurance services. The required inclusion of risk-sharing or limits is clear evidence of an intent to limit the PSN's risk, particularly when coupled with the fact that the arrangement covers predominantly services produced directly by the providers. This would open more options for beneficiaries by overcoming the problem of long delays (reportedly up to two years) in obtaining HMO licenses.

This is not to say the PSNs should not demonstrate their own financial ability to deliver services. PSNs should be subject to appropriate solvency requirements. These solvency requirements, however, should acknowledge that PSNs must invest most of their capital in delivering high-quality services, not creating cash reserves to pay claims. PSNs should be held to a solvency standard that takes into account the amount and type of risk the network takes on and its delivery assets, but ensures its ability to meet its obligation to Medicare beneficiaries. Compliance with the standards could be streamlined by requiring that PSNs obtain and submit independent actuarial certification about their compliance with the standards.

Quality issues

This is also an opportune time to completely re-examine Medicare requirements that address quality and access, and the provision of information to beneficiaries to help them choose plans and treatment options that ensure ready access to high-quality care. Standards should ensure access to providers on a timely basis and at the appropriate level of care. Standards should ensure an adequate number, geographic distribution and specialty mix of network practitioners and providers. They should also ensure that utilization review procedures encourage quality delivery of services, and are not used to restrict medically necessary services -- especially after-hours and emergency room services.

Quality assessment and improvement standards should require that providers in the network are chosen for how well they deliver care and with the expectation that they actively participate in an ongoing effort to monitor and improve care. Quality assessment measures should include the traditional clinical outcomes, but also begin to utilize patient-reported information on their functional ability after treatment, and on emotional and educational support from practitioners. As a safety valve and ongoing monitoring tool, provider-sponsored networks and other coordinated care systems should maintain easily accessible, responsive complaint and grievance processes. Consumers should feel their complaints are heard and that every attempt is made to settle disputes.

The responsibility for giving beneficiaries information to choose between networks must be shared by the Medicare program. While networks should not be precluded from advertising in local markets, the advertising should meet some common national standards. In addition, networks should be required to provide information in a simple standard format that HCFA would develop.

We also believe Congress should consider federal certification of PSNs to establish their ability to enter into direct risk-sharing arrangements with the Medicare program. We have been discussing a similar approach with Rep. Harris Fawell (R-IL), chairman of the House Committee on Economic and Educational Opportunities Subcommittee on Employer-Employee Relations, in the context of ERISA self-insured employer group health plans. Such a certification process would ensure that standards are applied without requiring the overly broad state regulatory framework for health carriers and HMOs.

To streamline standards enforcement, the Medicare program should consider using private accrediting bodies through deemed status where appropriate. However, this is a new area of standards development that requires a careful assessment of network and health plan standards, both public and private, before such an arrangement is implemented.

HCFA's Medicare Choices Demonstration Project

We had hoped that the Health Care Financing Administration's (HCFA) Medicare Choices demonstration project would open more doors for beneficiaries by exploring how Medicare can take advantage of delivery systems such as provider-sponsored networks. However, it would appear that the criteria for applicants could effectively require that applicants be licensed HMOs in all but possibly one of the nine metropolitan areas targeted by HCFA. Consequently, the project may be limited to demonstrating alternative payment methods for HMOs. While such efforts are needed, Congress may want to stimulate much broader efforts to bring Medicare into the future of health care delivery. Medicare beneficiaries should be able to continue relationships with local health care providers that they have built up over the years. Provider-sponsored networks can offer this option to them.

Conclusion

Mr. Chairman, America's hospitals and health systems are proud of the service they've provided for Medicare beneficiaries over the past 30 years. We're proud that we've been able to maintain high levels of quality, make new technology available to Medicare beneficiaries, and increase efficiency.

But we cannot continue to cut costs and become more efficient without a significant realignment of financial incentives. If PSNs cannot take some risk without being required to have an HMO license, most of our members will be driven away from incentive-based payment arrangements because they are either too small to accept full risk or because it takes too long to get an HMO license from their state.

Appropriate public policy is key to making sure the door is not shut on the provider-sponsored network option. Allowing provider-sponsored networks to contract with Medicare on a limited-risk basis opens doors for everyone involved: Medicare and the network's providers, and the beneficiaries themselves, who would be able to choose local hospitals, physicians and others organized to provide benefits in a coordinated and efficient manner. It's a choice they deserve to have.

Chairman THOMAS. Thank you very much.
Mr. Walworth.

**STATEMENT OF JAMES WALWORTH, PRESIDENT, HEALTH ALLIANCE PLAN OF MICHIGAN, DETROIT, MICHIGAN, ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA**

Mr. WALWORTH. Thank you, Mr. Chairman and Members of the Subcommittees. I am James Walworth, president, Health Alliance Plan of Michigan, and I am here today testifying on behalf of GHAA, the Group Health Association of America, the Nation's leading association for health maintenance organizations. Our 385-member HMOs account for more than 80 percent of the 50 million Americans who are today served through HMOs.

We are pleased to have been asked once again to testify before Congress and these Subcommittees with respect to the future of the Medicare Program. We look forward to continuing to work with Congress and the administration as you review the Medicare Program.

Medicare can best be strengthened, in our view, by offering beneficiaries the same kinds of choices that are already available to millions of working Americans in the private sector and those working for the Federal Government. In prior testimony before other Committees, we have put forth our view of the basic elements of that kind of an approach.

Today, at the request of these two Subcommittees, we will focus on the standards that should apply to the alternatives that may be created as part of the Medicare Program. In order to participate in Medicare today, HMOs and competitive medical plans must meet detailed standards on many aspects of their operations, from marketing, enrollment, disenrollment, infrastructure and access to care, to grievance procedures and appeal processes reporting disclosure, solvency standards, and other forms of enrollee protection.

While recognizing that their administration should be simplified and streamlined, we believe that these standards provide a very strong foundation for criteria that should apply to the full spectrum of options that may seek to participate in a reformed Medicare Program. Based on years of experience of Medicare contracting with the HMOs and CMPs, these standards are known to address certain fundamental issues that will remain as valid in the future as they are today.

These include, in particular, assurances that beneficiaries have the information necessary to make an informed choice among the options available and the information necessary to understand how to obtain the covered services through organized delivery systems, as well as under the traditional Medicare Program.

Second, to assure that enrollees have access to needed services; third, that those who will provide services demonstrate an accountability for the quality of care; fourth, that there are adequate mechanisms for resolving enrollee grievances; and, finally, that all the options that accept risk have financial capacity sufficient to provide those promised benefits.

GHAA believes that as the array of offerings available to Medicare beneficiaries expands, it is vitally important to maintain strong and comparable standards for all options. We believe that

States and the Federal Government can work in partnership and play equally important roles in achieving that goal, but with the Federal Government continuing to bear the responsibility for determining that the options available meet standards for entry into the Medicare Program, and for ensuring that they meet these and other rules for program participation on an ongoing basis.

However, where State licensure standards are at least as stringent as the Federal standards, plans should not be subject to unnecessary duplicative reviews. Under this framework, Medicare beneficiaries can be assured that all options available to them in all regions of the country are held to a consistent set of standards.

We believe and recommend that all organized systems of care, as well as providers under the fee-for-service Medicare Program, should meet comparable standards. This means that where options include similar elements or activities, those are the areas where comparable standards apply, particularly in issues of State licensure, quality, access, grievance procedure, solvency, marketing, and administration.

There are a couple of other areas I would like to quickly mention. We recommend that a statutory criteria be established for the waiving of the 50–50 rule with respect to enrollment in HMOs. Also, it is important and essential to avoid the inhibition of developing HMOs and other organized systems of care through such antimanaged care proposals and changes to antitrust laws as has been suggested.

We think that deemed status is also an appropriate role for the private sector with respect to issues of quality and standards and their application. While GHAA favors building on the existing standards, we do believe that there is room for improvement in the HCFA's administration of the program, particularly with regard to the processing of applications and the expansion of service areas.

We appreciate this opportunity, Mr. Chairman, to present our views. We know, too, that there will be efforts to relax some of the current standards. We think that, as you view those, it is essential that you keep in mind how they would affect the operation of the program.

We look forward to working with the Subcommittees on these issues and with Congress, as you go through this debate.

[The prepared statement and attachment follow. The Consumer Protection and Quality Assurance: Current Regulations and Standards for Medicare HMOs and CMPs are being held in the Committee's files.]

**STATEMENT OF JAMES WALWORTH, PRESIDENT**
**HEALTH ALLIANCE PLAN OF MICHIGAN**
**ON BEHALF OF GROUP HEALTH ASSOCIATION OF AMERICA**

Mr. Chairmen and members of the Committees, I am James Walworth, President of Health Alliance Plan of Michigan, and I am testifying today on behalf of the Group Health Association of America (GHAA). GHAA is the leading national association for health maintenance organizations (HMOs). Our 385 member HMOs serve 80 percent of the 50 million Americans receiving health care through HMOs today.

We are pleased to be asked to testify as your Committees explore the future of the Medicare program, and look forward to working with the Congress and the President in a bipartisan fashion on Medicare. GHAA believes that Medicare must be modernized to reflect the dramatic developments that have occurred in the private sector since Medicare was enacted 30 years ago. Medicare can best be strengthened by offering beneficiaries the same kinds of choices that are already available to millions of working Americans both in the private sector and in the federal government. Today, I would like to:

- o review GHAA's guiding principles for discussion of Medicare reform;
- o summarize briefly the recommendations GHAA has already made to Congress on the beginning steps needed to modernize Medicare; and
- o present GHAA's views on the standards that should apply to options available to Medicare beneficiaries in an era of expanded choice.

## Guiding principles for discussion

As you know, the health care environment of 1995 is vastly different than the one that prevailed in 1965, when Medicare was enacted. Fee-for-service coverage is no longer the predominant approach to coverage in the private sector. More than 60 percent of all working Americans with private health coverage now receive their care through HMOs and other organized systems of care. Medicare too is changing, but slowly -- only about 10 percent of today's Medicare beneficiaries are in HMOs. The result is that Medicare beneficiaries no longer have coverage that is typical of that available to the working population and do not derive the benefits of the choices available to other Americans.

Medicare must be updated to reflect the dramatic changes that have occurred in the private sector during the three decades since the program began. GHAA believes that Medicare can best be strengthened by giving beneficiaries the same kinds of choices that are already available to millions of working Americans, including federal employees and members of Congress. Medicare -- and the Health Care Financing Administration (HCFA) -- should be reoriented toward a model in which Medicare beneficiaries have the opportunity to choose from among a broad array of options that compete on the basis of quality, service, and cost, and are held to comparable standards. When beneficiaries can choose the option that best meets their needs, Medicare will benefit from the progress that has been made in the private sector.

GHAA believes that the following principles should guide discussions of Medicare reform:

- o **Beneficiary choices**: Medicare reform should be consistent with the promise of providing access to Medicare benefits that meet the needs of elderly and disabled Americans and offering beneficiaries choices comparable to those available to the working-age population. Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.
- o **Medicare standards**: Our experience also tells us that standards are vitally

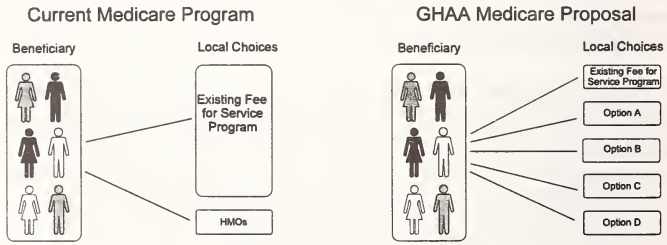
important. All organized systems of care, as well as providers under the fee-for-service Medicare program, should meet comparable standards in areas such as quality of care, access, grievance procedures, and solvency.

- **Medicare payments**: Medicare payments should permit widespread availability of organized systems of care, as well as the traditional fee-for-service option, for Medicare beneficiaries nationwide. The Medicare program should act in a fashion similar to private sector purchasers. This can be done by establishing the amount of funding available for benefits for all beneficiaries on both an aggregate and per beneficiary basis, with an equitable allocation of resources between organized delivery system options and the fee-for-service program. Total expenditures should be trended forward on an appropriate basis to meet program goals.

## Beginning steps

Looking at the current Medicare program and using the GHAA principles as a guide, the question, of course, is how to begin to take the steps necessary to modernize Medicare. Based on the practical and proven experience of our member plans in serving tens of millions of Americans, including three million Medicare beneficiaries, we have recommended a series of changes to transition from the current approach to a model based on beneficiary choices.

Figure 1




The changes are designed to foster expansion in existing Medicare markets, encourage new Medicare markets to emerge, permit the development of increased capacity for Medicare beneficiaries to enroll in organized options offered by HMOs and other entities, and provide the experience necessary to permit informed decision-making by the Congress on the future design of the Medicare program. We have recommended changes in the following five areas:

- improving beneficiary information, awareness, and enrollment process;
- expanding the infrastructure of choices available to beneficiaries;
- maintaining strong standards for options participating in Medicare;
- beginning to transition HCFA from a model that relies on fee-for-service regulation to one that relies on beneficiary choice model; and
- transitioning to improved Medicare payment methodologies.

**Maintain strong standards for options participating in Medicare**

In previous testimony, GHAA has focused on increasing the choices available to beneficiaries, and issues related to payment. Today, at the request of your two committees, we will focus on the standards that should apply to the alternatives to the traditional Medicare program that will be available in an era of increased beneficiary choice.

Strong and comparable standards: In order to participate in Medicare today, health maintenance organizations (HMOs) and competitive medical plans (CMPs) [1] must meet detailed standards on many aspects of their operations, including marketing, enrollment and disenrollment procedures, benefits, delivery system (access to care), quality assurance programs, grievances and appeals, reporting and disclosure, solvency, and other enrollee protections. Because a description of these standards would consume more time and space than this hearing permits, a chart summarizing them has been submitted for the record.

While recognizing that their administration should be simplified and streamlined, GHAA believes that these standards provide the best foundation for standards for assessing the full spectrum of options seeking to participate in a reformed Medicare program. Based on years of experience of Medicare contracting with HMOs and CMPs, these standards address certain fundamental issues that will remain as valid in the future as they are today, including:

- o assuring that beneficiaries have the information necessary to make an informed choice among the options available to them, and the information necessary to understand how to obtain covered services through organized delivery systems, as well as under the traditional Medicare program.

- o assuring that enrollees have access to needed care;

- o assuring that all who provide services demonstrate their accountability for quality of care;

- o assuring that there are adequate mechanisms for resolving enrollee grievances; and;

- o assuring that all options that accept risk have the financial capacity to provide promised benefits.

GHAA believes that as the infrastructure of offerings available to Medicare beneficiaries expands, it is vitally important to maintain strong and comparable standards for all options. Both the states and the federal government have important roles to play in achieving this goal. The federal government should continue to bear the responsibility for determining that options meet standards for entry into in the Medicare program and for ensuring that they meet these and other rules for program participation on an ongoing basis. However, where state licensure standards are at least as stringent as the federal standards, plans should not be subject to duplicative reviews. Under this framework, Medicare beneficiaries can be assured that all options available to them in all regions of the country are held to a consistent set of standards.

- o **Comparable standards**: All organized systems of care, as well as providers under the fee-for-service Medicare program should meet comparable standards in areas such as quality of care, access, grievance procedures, and solvency. This means that where options include similar elements or activities, they should meet comparable standards with respect to those elements or activities. For example, the same standards should

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[1] Competitive medical plans (CMPs) are HMOs that have not chosen to become federally qualified but meet similar federal standards. For the remainder of the testimony, we use the term "HMO" to refer to both HMOs and CMPs.

apply whenever options have delivery systems, engage in marketing activities or accept risk for providing services or benefits. Standards should include:

- -- State licensure: All options should be offered by state licensed entities, and all providers should be licensed, certified or accredited, as appropriate.

- -- Quality: All offerings and providers should have the capacity to develop reports on performance that permit comparisons among options and providers.

- -- Access: All options and providers should accept all beneficiaries who wish to enroll or who select those providers up to the limits of the capacity of such offerings/providers and without regard to health status.

- -- Grievance procedures: All offerings and providers should make available to beneficiaries procedures for hearing and resolving grievances under the Medicare program.

- -- Solvency: All offerings should be fiscally sound and meet standards for an initial deposit, initial net worth and ongoing solvency.

- -- Marketing and Administration: All offerings should provide to beneficiaries easily understood information that describes the coverage offered, the structure of the delivery system and rules and procedures for obtaining covered services. HCFA should work with entities offering these options to develop comparative information for beneficiaries that includes all of the choices available to those including the traditional Medicare program.

- -- Confidentiality: All offerings and providers should establish procedures for maintaining the confidentiality of patient records that are consistent with applicable laws.

- o **50/50 rule**: Statutory criteria in connection with waiving the 50/50 enrollment requirement for HMOs and other organizations offering organized options should be developed.

- o **Anti-managed care**: Attempts to limit choice by inhibiting the development of HMOs and other organized systems of care, such as anti-managed care proposals and changes to current antitrust law, should be rejected; where such anti-managed care laws exist, they should be preempted.

- o **Deemed status**: To enhance and streamline Medicare's quality assurance program, organized offerings that are accredited under standards at least as stringent as those established by the Medicare program by private sector organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), and the Accreditation Association for Ambulatory Health Care (AAAHC), should be deemed to comply with applicable Medicare quality standards.

As a broader range of options become available to Medicare beneficiaries the standards established in all of these areas must be comparable. We have carefully considered the way in which the current framework of federal regulation for HMOs and CMPs can form the foundation for this expanded participation. Our recommendation, one that is consistent with an approach that has been adopted by the NAIC, is to require that all options that involve comparable elements or activities should meet the comparable standards for those activities.

How would this work?

Many organized systems of care provide services to their enrollees primarily through affiliated providers, and ordinarily will not cover services furnished by others. Because the universe of providers available to their enrollees is defined, the current framework requires these plans to meet standards designed to assure access to care through those providers. Indemnity coverages pay for services but do not take responsibility for providing care through arrangements with providers. Such plans would be subject different standards for access, because they do not perform coordination of care functions that are carried out by HMOs.

By contrast, every health plan seeking to participate in the Medicare program will engage in marketing activities in order to enroll Medicare beneficiaries; thus, they should be held to comparable marketing standards in areas such as the accuracy of their marketing materials and avoiding prohibited marketing activities, such as door-to-door solicitation and offering gifts to induce enrollment. Likewise, every option to which Medicare makes a capitated payment for an enrolled beneficiary -- regardless of who owns the entity offering the option or how its delivery system is organized -- has accepted risk and must be held to comparable solvency standards designed to ensure it is able to deliver promised benefits without interruption.

Requiring all options to meet comparable standards is critical to ensuring that all beneficiaries can have the same confidence in the soundness of the option they select. It is also critical to ensure that all options compete under comparable rules on the basis of quality and cost effectiveness. Therefore, the standards established for the range of choices under a modernized Medicare program are one of the paramount elements that make the choices meaningful for beneficiaries.

GHAA strongly believes that the way you resolve the issue you are considering here today will be critically important in determining the success or failure of any Medicare reform initiative emerging from the 104th Congress. The standards that Medicare options must meet will have a major impact on whether or not the new choices available to beneficiaries in a restructured Medicare program are capable of delivering the benefits and quality of care they have promised to provide -- and of doing so over the long run, not just for a year or two. And this, in turn, will help determine whether Medicare beneficiaries see them as reasonable alternatives to the current fee-for-service Medicare program.

Congress will undoubtedly be asked to relax some of the current standards as it expands the number and type of available health choices for Medicare beneficiaries. Those making such requests may argue that a particular option is distinguishable from existing HMOs -- or that temporary relief is needed during an initial start-up phase. While GHAA does not necessarily believe that all such requests should be rejected out-of-hand, it believes that the greatest risks to Medicare reform lie in its initial stages, and we urge Congress to evaluate requests for differential standards in light of whether, if granted, they will increase or decrease the likelihood that the option in question will meet the needs and expectations of Medicare beneficiaries and remain financially viable. It will not take many health plan failures to discredit Medicare reform in the eyes of the public -- setting back reform and imposing a substantial financial burden on the program and the taxpayer who ultimately stands behind the failed plan.

Streamlined administration: While GHAA favors strong and comparable standards for all options -- and believes that existing HMO/CMP standards provide the best framework upon which to build -- there is room for improvement in the way the current standards are being administered. Changes in HCFA's focus on individual claims payment and basic improvements in administrative mechanisms can help enhance the modernization of the choices available to beneficiaries.

- **Transition to new model**: HCFA needs to begin the process of reorienting its

approach from management of the transactions in a fee-for-service system to implementation of a beneficiary choice model oriented toward oversight of organized delivery systems.

- **Administrative procedures and processing of applications**: In the short-term, HCFA should take immediate steps to improve administrative procedures and processing time:

  - reduce the time it takes to process and approve two types of applications from HMOs: initial applications to serve Medicare beneficiaries, and applications from approved plans to expand their service area and be able to serve additional Medicare beneficiaries;

  - simplify administrative procedures for submission and processing of applications (i.e., permit information associated with the application to be submitted on computer disk); and

  - streamline oversight of multi-state organizations, for example by eliminating duplicative filing requirements and facilitating communications among regions.

- **Policy guidance/ regional variations**: HCFA should take steps to identify and narrow the variation in interpretation of policy by regional offices and promote consistency in decision making in such areas as review and approval of contracts, products, and marketing materials; this should include the development and issuance of guidelines for regional offices.

Anti-managed care proposals: Finally, we would be remiss in testifying on standards for a broadened range of Medicare options if we failed to address proposals that would require HMOs and other organized offerings to contract with certain providers and to follow complex and burdensome procedures for credentialing and selecting providers. GHAA opposed such proposals last year in the context of comprehensive health care reform, and we oppose them now in the context of Medicare reform. Current HMO/CMP standards address the issue of beneficiary access to care in considerable detail and are designed to protect consumers in key areas. Like other anti-managed care proposals, these proposed restrictions run counter to the central requirements of a system that is based on an array of choices competing on their ability to provide high quality, cost-effective care. Such provisions, if enacted, could undermine the ability of HMOs and other organized systems of care participating in the Medicare program to select the physicians best suited to the needs of their members.

**Conclusion**

GHAA appreciates this opportunity to present our views about modernizing the Medicare program and establishing standards for the choices that will be available to beneficiaries. We look forward to working with the Committee on this issue, and I would be pleased to answer any questions that you may have. Thank you.

GHAA

# Quality Assurance in HMOs
## Medicare Requirements and NCQA Accreditation Standards[1]

[1] In this document. "CFR" refers to the Code of Federal Regulations, "Review Guide" refers to the Medicare Contractor and Performanace Monitoring System: Review Guide (External) (1993 revision). All NCQA references are to NCQA Standards for Accreditation, 1994 edition.

| Subject | Regulations | Agency Guidance | NCQA |
|---|---|---|---|
| **Quality Assurance Program**<br><br>§1876 (c)(6) Social Security Act | Ongoing quality assurance program: must have ongoing quality assurance program meeting four conditions:<br><br>Stresses health outcomes<br><br>Provides review by physicians/other health professionals of the process of providing health services;<br><br>Data collection, interpretation, intervention: uses systematic data collection of performance, patient results; interprets data to practitioners; institutes needed change<br><br>Includes written procedures for taking remedial action when<br>• inappropriate or substandard services are provided<br>• services that ought to be provided have not been provided.<br><br>42 CFR 417.106(a); 417.418 | Ongoing QA program<br>See also: Review Guide section VI, pp VI 1,2<br><br>Stress on health outcomes See also: Review Guide, section VI, ppVI 2,3.<br><br>Peer review<br>See also: Review Guide, Section VI, p. VI 3.<br><br>Systematic data collection<br>See also: Review Guide, section VI, pp. VI 3,4.<br><br>Remedial action<br>See also: Review Guide, section VI, p. VI 4. | Ongoing quality improvement (QI) program is designed to monitor and evaluate quality and appropriateness of care and service provided members and pursue opportunities for improvement. QI 5.0 - 5.4.3<br><br>Clearly defines and assigns to appropriate individuals organizational arrangements and responsibilities for QI processes. QI 1.0 - 2.5<br><br>QI committee is accountable to the HMO's governing body. Demonstrates evidence of a formally designated structure, accountability at the highest levels of the organization and ongoing and/or continuous oversight of the QI.<br>QI 2.0 - 2.5<br><br>Documents and reports to appropriate individuals findings, recommendations, actions taken as a result of QI activity. QI 3.0 - 3.3<br><br>Takes an active role in improving the health status of members. QI 8.0 - 8.3 |

| Subject | Regulations | Agency Guidance | NCQA |
|---|---|---|---|
| Quality Assurance Program | | | Incorporates into all provider contracts and employment agreements requirements to participate in QI activities Specifies that hospitals and other contractors will allow access to medical records of HMO.<br><br>Uses measurements, QI data collection, and analysis to track quality improvement. QI 9.0 - 9.2.1<br><br>Establishes standards for the availability of primary care providers and access. Assesses performance against these standards. QI 7.0<br><br>Uses a variety of mechanisms to identify important areas for improvement and to set meaningful priorities. QI 6.0 - 6.4<br><br>Takes actions to improve quality and assesses the effectiveness of these actions through systematic follow-up. QI 10.1 - 10.3 |

| Subject | Regulations | Agency Guidance | NCQA |
|---|---|---|---|
| **Quality Assurance Program** | | | Evaluates the overall effectiveness of its QI program. QI 11.0 - 11.2<br><br>If any QI activities are delegated to contractor, demonstrates evidence of oversight of the contracted activity. QI 12.1 - QI 12.2.2 |
| **Utilization management** | HMO must have effective procedures to monitor utilization and to control the costs of services and to achieve utilization goals, which may include mechanisms such as risk sharing, financial incentives, or other provisions agreed to by providers.<br><br>42 CFR 417.103(b) | See also: Review Guide, section III, code UM01, p. III 1. | HMO must have a documented utilization management program description that describes both delegated and nondelegated activities. UM 1.0<br><br>Uses qualified medical professionals to supervise review decisions where procedures are used for preauthorization and concurrent review. UM 2.0 - 2.2<br><br>Has a set of written UR decision protocols based on reasonable medical evidence. UM 3.0 -3.3.1<br><br>Efforts are made to obtain all necessary information, including pertinent clinical information, and consultation with treating physicians as appropriate. UM 4.0 |

| Subject | Regulations | Agency Guidance | NCQA |
|---|---|---|---|
| **Utilization management** | | | Makes decisions in a timely manner depending on the urgency of the situation. UM 5.0<br><br>Clearly documents reasons for denial and makes them available to member. Denial notification includes appeal process information. UM 6.0<br><br>Has policies and procedures in place to evaluate appropriate use of new medical technologies. UM 7.0 - 7.2<br><br>Has mechanisms to evaluate the effects of the program using member satisfaction data, provider satisfaction data, and/or other appropriate means. UM 8.0<br><br>If the HMO delegates any UM activities to contractors demonstrates evidence of oversight of the contracted activity. UM 9.0 |

Chairman THOMAS. Thank you very much, Mr. Walworth.
Ms. Lehnhard.

**STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, POLICY AND REPRESENTATION, BLUE CROSS & BLUE SHIELD ASSOCIATION**

Ms. LEHNHARD. Mr. Chairman and Members of the Subcommittees, my name is Mary Nell Lehnhard. I am senior vice president for Policy and Representation for the Blue Cross & Blue Shield Association, and I am here representing the 68 Blue Cross & Blue Shield plans.

We appreciate this opportunity to testify on the appropriate standards that you are considering in introducing more choice of programs into the Medicare Program. Blue Cross & Blue Shield plans are eager to participate in broadening the choice of options to Medicare beneficiaries. These plans currently enroll more than 30 million Americans in a range of managed care network products that include HMOs, PPOs, and point-of-service products. Thirteen Blue Cross & Blue Shield plans currently have risk contracts, and 30 plans are in the process of qualifying for these contracts.

As you consider specific standards for these new types of health plans, we urge you to keep in mind three general recommendations. First, the existing standards in 1876 which set the standards for the risk contracts already provide a comprehensive framework for consumer protection. We do not think you need to look any further. These standards cover such protections as open enrollment, solvency standards, consumer grievance procedures, health plan marketing, coverage of emergency and out-of-network services, explanation of benefits, and continuation of coverage upon contract termination. We have appended to our testimony a list of those standards. We think these standards have served beneficiaries very well and we urge you to resist more regulation.

Second, in applying these standards to the new options, we recommend three things: First, apply these standards uniformly to all types of health plans that offer coverage to Medicare beneficiaries. This includes health plans offered by physicians and hospital organizations, the so-called PHOs. Second and very importantly, require all participating health plans to be licensed by the State in which they operate. Again, this would include the PHOs.

Health plans that participate in Medicare are going to be accepting. All of them, whether a PHO, HMO, or point of service are going to be accepting an insurance risk of providing services in exchange for a capitation payment from Medicare. This is the business of insurance, and beneficiaries will not be protected unless the health plans meet very carefully designed insurance or HMO laws on solvency and other consumer protections.

The National Association of Insurance Commissioners is currently working aggressively on a strategy to assure that PHOs that accept capitation payments are licensed either as insurance companies or HMOs in the States.

The third recommendation with respect to the application of those existing standards is to use private accreditation, where possible. You have heard today that Medicare has already laid a foundation for this. Hospitals that are accredited by JCAHO are

deemed to be in compliance with the Medicare standards. In other words, it is very simple: Congress sets the standards and if a private accreditation organization wants to participate in deeming those standards, then their private rules have to encompass Medicare or be equal to or better than, and HCFA would make that determination.

Beyond the obvious cost implications of reducing costs for health plans, private accreditation should be encouraged, because it would first say to beneficiaries that their health plan meets the same high standards that major employers are demanding, and, second, provides beneficiaries the advantages of private market demand for not just the infrastructure rules, but the performance measurements and the information on performance that would be given to purchasers.

Our third and final overall recommendation as you develop these rules is to recognize the two facets growing in most popular managed care products. PPOs encourage the use of a health plan's network by offering lower cost sharing when the network providers are used. And point of service, actually the most popular product, point-of-service products rely on lower cost sharing to encourage use of the network providers, but they include certain important features of HMOs, primarily primary care referral requirement and authorization for specialty services.

Mr. Chairman and Members of the Subcommittees, this is a summary of our recommendation and we look forward to working with you.

[The prepared statement and attachment follow:]

**STATEMENT OF MARY NELL LEHNHARD**
**SENIOR VICE PRESIDENT**
**BLUE CROSS & BLUE SHIELD ASSOCIATION**

Mr. Chairmen, and members of the committees, I am Mary Nell Lehnhard, Senior Vice President, of the Blue Cross and Blue Shield Association, the coordinating organization for the 68 independent Blue Cross and Blue Shield Plans. Collectively, the Plans provide health benefits protection for 68 million people — including more than 7 million Medicare subscribers with supplemental (Medigap) insurance coverage and 200,000 beneficiaries enrolled in Blue Cross Blue Shield HMOs. I appreciate the opportunity to testify before you on ways to strengthen and improve the Medicare program.

Our statement today primarily addresses the issue of setting appropriate standards for private health plans offered to Medicare beneficiaries and the role of federal, state and private agencies in the oversight of these standards. In our view, the structure of standards established under Section 1876 by the Social Security Act offers a comprehensive framework for health plans to be made available to seniors. We recommend, in addition, that:

- health plan standards be applied uniformly to all health plans, including those sponsored by physicians and hospitals (PHOs);
- all health plans offered to Medicare beneficiaries be licensed to offer health care coverage by the state and
- that Medicare expand its reliance on private accreditation to certify compliance with applicable federal health plan standards.

In addition, we recommend that Medicare move quickly to expand the availability of health plans such as PPOs and Point-of-Service plans.

In 1965, the Medicare program was designed to give seniors and the disabled access to mainstream medical care and coverage modeled after the most common kind of health insurance available to those under age 65 — health insurance that was pioneered by Blue Cross and Blue Shield Plans. Since 1965, mainstream coverage in the under 65 population has changed and Blue Cross and Blue Shield Plans have led the way with innovative managed care options.

In an effort to make more comprehensive benefits available at lower cost, Blue Cross and Blue Shield Plans have successfully developed and marketed to the working population a wide range of health plan options. Blue Cross and Blue Shield Plans Plans, collectively, have enrolled nearly 30 million subscribers in managed care products. Blue Cross and Blue Shield, collectively, have the largest number of subscribers enrolled in HMOs.

Medicare, however, has not changed. Only 10 percent of Medicare beneficiaries have enrolled in HMOs. More tellingly, the options that dominate the under-65 market — Preferred Provider Organizations (PPOs) and Point-of-Service (POS) products — are not available to beneficiaries. Medicare can best be strengthened by making available to Medicare beneficiaries the same broad range of options that have been widely adopted by the under-65 population.

Blue Cross and Blue Shield Plans are working to make the current limited Medicare options available to seniors. Thirteen Blue Cross and Blue Shield Plans offer HMOs or similar coverage to Medicare beneficiaries. As of the end of last year, Blue Cross and Blue Shield HMOs enrolled more than 200,000 Medicare beneficiaries, and the number is growing rapidly. In addition, nearly 30 Blue Cross and Blue Shield Plans are in the process of developing and launching risk-based HMO products to offer to Medicare beneficiaries.

In the more traditional area of Medigap coverage, Blue Cross and Blue Shield Plans have also been innovators. Medicare Select products offer beneficiaries more affordable Medigap coverage that relies on a selected network of providers. The Select products are, in fact, virtually the only way Medicare beneficiaries can obtain

PPO-like or POS-like coverage. We believe that these products have a vital role to play in offering superior coverage to Medicare beneficiaries and have demonstrated the need for expanding the range of health plan options in a revitalized Medicare program.

**Guiding Principles for Reform**

We believe that Medicare should move beyond the current limited options offered to seniors. Medicare should apply the lesson learned by the private sector that private competitive markets offer a better solution to the problem of controlling costs, assuring quality, and providing better coverage than central bureaucratic controls. In applying this lesson, we believe that three principles should guide the effort to revitalize the Medicare program.

- Medicare beneficiaries should be able to obtain coverage from the same range of mainstream health care coverage options that millions of working men and women rely on, including HMOs, PPOs, and Point-of-Service plans, in addition to the traditional indemnity coverage offered by the Medicare program.
- Medicare beneficiaries should be able to choose coverage within a competitive market in which private organizations design, develop, manage and offer innovative products to provide beneficiaries better coverage at a better total cost. The federal government should continue to offer the traditional program as an option for beneficiaries — but should rely on private health plans to offer alternatives to traditional coverage.
- Medicare should rely on a combination of federal, state and private accreditation organizations to make available to beneficiaries licensed health plans that offer high quality care and good value, and to supply beneficiaries with the comparative information that will enable them to select the health plan that best meets their needs.

The federal government should strive to establish a competitive private market that meets the needs of seniors for high quality medical care and coverage. The federal government should protect beneficiary interests by adopting regulations that promote vigorous, responsible competition by emphasizing outcomes and performance over process and paper work compliance. A program restructured along these lines would work as follows:

- Medicare beneficiaries would have the option of obtaining coverage from among certified private health plans or the traditional Medicare program.
- Only health plans that are offered by licensed insurers and HMOs (or other licensed entities), and meet federal standards would be able to participate. To the extent possible, the federal government should rely on private certification and state licensure to determine compliance with standards.
- Health plans would have maximum flexibility to design products that meet the diverse needs of the Medicare population within basic standards for adequacy of benefits.
- Medicare would determine the contribution that it would make toward the cost of coverage provided by a health plan related to the actual costs of Medicare beneficiaries.
- Beneficiaries would select a health plan and pay the health plan the difference between the Medicare contribution and the premium established by the health plan. Beneficiaries would be able to switch health plans at least annually.

A restructured, competitive Medicare market can provide beneficiaries access to innovative health plan coverage options that millions of working Americans currently enjoy.

**Specific Principles for Health Plan Standards**
Standards to safeguard vital beneficiary interests are a necessary part of any Medicare reforms designed to expand access to private health plans. Standards should be designed to encourage, not stifle, innovation in the design of products and the management of costs. They should emphasize the results that the health plan delivers to its subscribers, not detailed procedural requirements.

The existing requirements for Medicare capitated programs, Section 1876 of the Social Security Act, establish a comprehensive framework for consumer protections. (An outline of these requirements is attached.) These standards address:

- open enrollment;
- solvency;
- health plan capacity;
- grievance procedures;
- health plan marketing;
- coverage of emergency services;
- continuation of coverage upon termination of contracts;
- explanation of benefit limitations such as requirements to use network providers; etc.

We believe that this extensive list of standards speaks for itself. Even a cursory review of the attachment suggests that health plans do not suffer from a lack of standards. Congress should resist calls for still more regulation of the details of provider selection and contracting or utilization management. We believe that the current standards sufficiently protect consumer interests.

In applying these standards to health plans, however, we believe that Congress should:

- uniformly apply the same health plan standards to all types of health plans offering coverage to Medicare beneficiaries, including health plans sponsored by physicians and hospitals (PHOs);
- require all participating health plans to be licensed to offer health benefit plans by the states in which they operate;
- rely more extensively on private accreditation or state certification to identify the plans that comply with its requirements.

A few comments on the second and third of these three points is in order. State licensure is important to make sure that the health plans available to seniors meet solvency and other financial standards. Federal law should, however, preempt state laws that restrict the ability of managed care plans to actually manage costs on behalf of their subscribers.

Private accreditation would reduce the Medicare program's administrative costs and avoid imposing duplicative costs of regulatory compliance on health plans and consumers. Medicare has successfully relied on private accreditation to determine compliance with the Medicare conditions of participation for hospitals. Hospitals that are accredited by the Joint Commission for the Accreditation of Healthcare Organizations are 'deemed' to be in compliance with the Medicare standards for hospitals. Those hospitals that are not accredited (for the most part small, rural hospitals) may be certified by the states under cooperative agreements with the federal government. We believe this model has potential application to health plans.

The private accreditation organizations that employers are beginning to use to certify their health plans offer a foundation for Medicare to use to certify compliance with its standards. We believe, however, that accreditation should be one means of

demonstrating compliance with Medicare health plan standards, not a requirement. The purpose of accreditation is to reduce administrative costs by accepting a private certification as evidence that the health plan satisfies Medicare standards. Medicare would determine whether an accrediting organization's standards are, in fact, at least as rigorous as Medicare's own standards.

We believe that using accreditation to certify compliance with federal health plan standards has significant merit for two additional reasons. It would say to beneficiaries that the health plan meets the same high standards that health plans offered to millions of employed Americans meet.

In addition, private accreditation is demonstrating innovative approaches to setting standards and reviewing health plan performance that will keep pace with the demands of a competitive — and demanding — marketplace. For example, NCQA has pioneered the development of methods of measuring performance and is using these measures both in the accreditation process and as a means of providing comparative performance information to purchasers. We believe that Medicare should learn and benefit from this private sector innovation.

**Standards for Health Plan Options**

Medicare's rules and regulations governing benefit design are showing their age. For all practical purposes, Medicare limits the private health plan choices that are available to beneficiaries to those that were available in the early 1970s: traditional indemnity coverage and the close-panel HMO.

The Medicare program is making some attempt to expand the range of choices available to beneficiaries. We support these efforts, but believe that Medicare should go further, faster. There is today — after more than fifteen years of development and real-world testing in the market — nothing experimental about products that combine a provider network with more limited coverage of out-of-network services. Medicare should take steps to rapidly expand the availability of two well-tested health plans:

- Preferred Provider Organization products which would create incentives for consumers to use the health plan's provider network in the form of lower cost sharing when a consumer receives care from a provider that is part of the health plan's provider network.
- Point-of-Service products also rely on lower cost sharing to encourage use of the health plan's provider network, but they include other features of HMOs, including primary care referral and authorization for specialist services.

In both types of products, when a subscriber is referred to a non-network physician or other provider for services that are not available within the provider network, the services will be covered as an 'in network' service (i.e., at the lower cost sharing amount).

Beyond this relatively simple rule, the design of out-of-network benefits should be left substantially to the dictates of the market place. Federal law should not prescribe, in detail, cost sharing for out-of-network services. Such regulations, while well intentioned, will increase the cost of coverage by limiting the incentives for subscribers to use the providers that have agreed to participate in the health plan's provider network.

**Conclusion**

We appreciate this opportunity to present our perspectives on Medicare reform, generally, and the more specific changes that are needed in health plan standards. We believe that Medicare already has in place a comprehensive set of health plan standards. Improvements can be made in three areas:

- the uniform application and enforcement of health plan standards to all types of health plans offered to seniors;
- allowing only entities that are licensed by states to offer health plans to make coverage available to Medicare beneficiaries; and,
- the introduction of private accreditation by organizations recognized by Medicare as adopting standards at least as rigorous as those established in federal law as an alternative means of demonstrating compliance with health plan standards.

We look forward to future opportunities to share with the Committee the results of our analyses as they are completed over the upcoming weeks and to work with you as you take up the complex challenge of bringing Medicare into the 1990s and putting it on a sound footing to face the 21st century.

**Attachment: Section 1876 standards**

Section 1876 of the Social Security Act already establishes a comprehensive framework of consumer protection regulations. Section 1876(c) establishes a broad range of standards designed to protect consumers:

- Subsection 1876(c)(2)(A) requires health plans to cover the services covered under Part A and B of the traditional program and allows health plans to offer supplemental benefits as an option available to beneficiaries.
- Subsection 1876(c)(2)(B) requires risk-contractors to comply with Medicare's national coverage determinations or policies.
- Subsection 1876(c)(3)(A) requires risk-contractors to have an annual 30 day open enrollment period, and to maintain continuous open enrollment for any beneficiary who loses coverage because another risk-contractor's contract is terminated.
- Subsection 1876(c)(3)(B) requires health plans to terminate a subscribers enrollment within one month of the subscriber's notice of termination.
- Subsection 1876(c)(3)(C) requires marketing materials and practices of risk-contractors to be approved by the Secretary and prohibits the use of materials that are inaccurate or misleading.
- Subsection 1876(c)(3)(D) prohibits risk contractors from refusing to enroll or renew coverage on the basis of a beneficiary's health status.
- Subsection 1876(c)(3)(E) requires risk contractors to provide subscribers with an explanation of:

  - benefits,
  - out-of-network coverage,
  - out-of-area coverage,
  - emergency coverage, and
  - appeal rights/procedures.

- Subsection 1876(c)(3)(F) requires risk contractors to provide 'continuation coverage' in the form of supplemental benefits for up to six months in the event that it terminates its contract with Medicare.
- Subsection 1876(c)(4) requires risk contractors to make services "available and accessible" to all subscribers with reasonable promptness and whenever medically necessary 24 hours a day and seven days a week.
- Subsection 1876(c)(5) requires risk contractors to establish grievance procedures. It also allows members who are dissatisfied with the outcome of the grievance procedures to submit unresolved disputes to an appeal to the Secretary and to seek judicial review.
- Subsection 1876(c)(6) requires risk contractors to establish a quality assurance program for the health services that it provides to its subscribers.
- Section 1876(c)(7) limits the liability of the risk-based contractor for primary coverage of medical care that is in progress at the time the beneficiary elects coverage from the risk contractor.
- Section 1876(c)(8) requires risk contractors to comply with Medicare regulations concerning advance directives.

In addition to these standards,

- Section 1876(h) establishes solvency standards; and,
- Section 1876(i) establishes various administrative standards that risk contractors must meet, including:
  - prohibitions on actions designed to deny or discourage enrollment by beneficiaries in need of substantial future medical services;
  - requirements for review by Peer Review Organizations; and,
  - restrictions on the type of contractual relationships that the health plan can enter into with providers.

Chairman THOMAS. Thank you very much for your testimony.

Does the gentleman from North Carolina wish to inquire?

Mr. BURR. Thank you, Mr. Chairman.

Dr. Bristow, the rest of the panelists thank you. We just saw each other last week, so I will be very brief with you, because I have had an opportunity recently.

Dr. Bristow, does the AMA believe that a market-driven system can meet or exceed the quality of care standards currently under the HCFA driven plan?

Dr. BRISTOW. Thank you, Congressman. We certainly do believe that that is feasible to do by utilizing a good deal of the private sector efforts that are already underway, some of which you have heard testimony from earlier today. We believe that by bringing those private sector coordinates together with representation from government, the insurers, the purchasers in the form of business and consumers, that certainly one could be able to develop the sort of guidelines that are needed for assessing outcome studies, assessing effectiveness studies, putting together practice guidelines that would, we believe, be even more effective in terms of assuring quality care to Medicare recipients than they have today.

Mr. BURR. Let me ask you a question as it relates specifically to your proposal. You mentioned that physician networks are able to assume risk, effect self-insure by securing the risk with their assets and their services. Yet, you also acknowledged that these groups lack capital, the management infrastructure, and I think to some degree the resources that managed care companies currently have in the marketplace.

I guess my question would be, help me sell the fact that a decision to go to something like what you are proposing is responsible on the part of the Congress of the United States.

Dr. BRISTOW. The rationale behind our suggestion is that the physician and provider network would already have that which an insurer would have to go out and purchase and therefore has the capability, if there is a shortfall in terms of funding, to still provide the services by virtue of the contractual arrangement that they have made. So capital is not important. Capital is still important, but the degree of capital reserves that an insurer has to have we believe would be excessive for those who have the capability of assuring that the services are going to be provided.

Mr. BURR. Let me move quickly, if I can, because the clock in Ways and Means is much quicker than the clock in Commerce. Mr. Sprenger, risk reward savings, could you define that for me?

Mr. SPRENGER. Sure, this is where you accept a certain amount of risk within a quarter in that if you can help save costs, you get to keep some of that reward.

Mr. BURR. Insurer or beneficiary?

Mr. SPRENGER. The insurer and the provider.

Mr. BURR. The reason I ask is that the administration has referred to that as financial coercion and would be vehemently opposed to any sharing of those savings with seniors in this country, and I think that testimony has already been made.

You indicated that a partial capitation arrangement might be an option with Medicare Programs. I think the exception would be that you would propose not to assume the risk for the high-cost

cases or the worst case scenarios. Was that an accurate description?

Mr. SPRENGER. No, not at all. What it was was a shared risk. We agree with my colleagues at the table here who talk about the fact that if we as a group of providers are going to become an insurance company and assume all of the same risk that they assume, we need to be regulated and we need to be licensed in the same way.

What we are talking about is there are parts of this country that——

Mr. BURR. I can see people turning to me saying if we allow you to assume a level of risk up to a point, you have written a plan that lets them really skim the cream.

Mr. SPRENGER. You would have all the same requirements in terms of who you enroll into that risk. This would not be creaming off. By risk, I am talking about the risk of taking care of an individual, not risk by their health condition.

Ms. LEHNHARD. Congressman, could I interject here?

Mr. BURR. Yes, ma'am.

Ms. LEHNHARD. I think it is very important to realize that State licensure for HMOs and particularly insurance companies already recognize that different organizations have different levels of risk. We are subject to a range of different reserve requirements based on different types of business we have. The business that we have with HMOs that we provide only a stop loss, we do not have to have the same level of reserves for.

What I think is very important to realize is that the contract that a PHO would have with Medicare to accept the capitation payment, that transfers risk and the PHO would further transfer risk to the physicians participating. That is another contract. A number of States have already said that is illegal, unless they are licensed as an insurance company or an HMO. They do not have to reserve at the level that our fully insured business does. There is adequate adjustment for that.

Mr. BURR. Mr. Chairman, one last question, if I may. I believe this is very important and I would like to direct this to Ms. Lehnhard. If we in fact try to inject choice into the senior self-care system, how many options do you see that Blue Cross & Blue Shield itself creates for that possible scenario?

Ms. LEHNHARD. In addition to the current HMO option, we think there are two that we would like to put on the table, and that is one of service, which is by far and large the most rapidly growing option, and that lets people go outside the network when they need to, and also the preferred provider option. What is ironic is that the options that people are voting with their feet on are most popular and not available to Medicare beneficiaries.

Mr. BURR. In fact, the debate is not over HCFA as it exists and an HMO. We are not limited to two choices?

Ms. LEHNHARD. We think the basic program should continue to be available, but we think you can put at least HMO point of service and PPO very distinct products on the market.

Mr. BURR. I thank all of you. We have run out of time. Mr. Chairman, I yield back.

Chairman THOMAS. The gentleman's time has expired. I will tell the gentleman that he perhaps inadvertently reinforced Einstein's

theory of relativity, because I understand that the Commerce clock is 5 minutes and our clock is 5 minutes. The difference is you may be having more fun here than in Commerce. [Laughter.]

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

I have basically two questions. I wish we had more time, but the Chair wants to cover a lot of ground here today. I referred earlier to a letter written by Secure Horizons—Pacificare, a for-profit operator of health plans, in responding to an advocacy group representing a patient who was unhappy. What Secure Horizons says is please be advised that Secure Horizons is not a provider of medical care; rather, it pays independent health care providers and the physicians and other providers of treatment that are independent, basically saying to the patient, I am sorry, we are not going to tell you. The last paragraph says, "In accordance with the California Health and Safety Code, the results of our quality assurance reviews are kept confidential."

In their marketing brochures, while I suppose a lawyer would say they skimmed by here, they say that by administering and coordinating your benefits, we are able to deliver comprehensive health care coverage efficiently and cost effectively. They go on to say that they want virtually no paperwork and they want to be the premier health care organization, and so forth.

My sense is that they are selling one thing and providing another. So I would ask each of you—and I have looked at your testimony and I think all of you advocate choice and having the beneficiaries be able to select—two questions. Do you not all think that the results of quality surveys or accreditation surveys or whatever other empirical data and/or subjective data that is available should be made available to beneficiaries? That is one question.

The other question that I would ask is whether all of you feel that the entities that you represent will be able to provide or continue to provide quality care, if there is over the next 7 years a $452 billion reduction in payments for both Medicare and Medicaid? I know the American Hospital Association has suggested $160 billion. That leaves you $100 billion light just for Medicare. But I want to know whether you think that $452 billion in the aggregate is about the right amount, too much of a cut, or too little.

Dr. Bristow, should rankings or studies be made available to beneficiaries to help them judge?

Dr. BRISTOW. Congressman, we feel very strongly that patients should have as much information about the quality of care that they are trying to select among as possible.

Mr. STARK. How about getting the numbers. Is $452 billion about right, too big a cut, too little a cut?

Dr. BRISTOW. We have not examined numbers per se. What we have done is said that we believe that we can have quality——

Mr. STARK. The light is going to go on.

Dr. BRISTOW. I am sorry.

Mr. STARK. Mr. Sprenger, should the studies and the reviews be available to——

Mr. SPRENGER. Absolutely, and in the system I represent, we have 99 percent approval from our Medicare enrollees.

Mr. STARK. What about the $452 billion in cuts?

Mr. SPRENGER. I can say that cannot happen without some change. Some change needs to occur, and what is the amount——

Mr. STARK. Do you think your members could continue to provide good quality care with those big cuts?

Mr. SPRENGER. I do not know what the right number is. We did support $160 billion, as you referred to, but we know that we can only approach the numbers that we are trying to approach if we do move into more coordinated care programs with our seniors.

Mr. STARK. Mr. Walworth.

Mr. WALWORTH. Again, I would respond in much the same way as the prior two panelists. I think that there is no question that studies and comparable factors ought to be part of a program, and I think that is one of the critical standards that needs to be developed.

Mr. STARK. And made public?

Mr. WALWORTH. And made public. Just to clarify—and I do not know the specifics of the Secure Horizons Program that you referenced—I think that there is an issue of confidentiality related to each specific case review that takes place.

Mr. STARK. This is the plan's ranking, not the——

Mr. WALWORTH. I think that there is no question but what——

Mr. STARK. How about the number?

Mr. WALWORTH. I think the number again is part of the whole debate we are engaged in and you——

Mr. STARK. You do not have an opinion of whether it is just right, too high or too low?

Mr. WALWORTH. I do not know the answer, because part of that is related to the question of exactly how are we going to respond and change the Medicare Program.

Mr. STARK. I will see if Mary Nell wants to weigh in on this.

Ms. LEHNHARD. We have supported the private accreditation. It is my understanding that NCQA on the infrastructure rules makes that public to purchasers, and on the performance standards they are moving into, HEDIS, the primary objective is to make that available to purchasers, so it would be available.

Mr. STARK. It is a California law that they are hiding behind, and I do not really know what the Federal law is. I just think if we are going to ask the people to make choices, they have got to have something to compare besides advertising brochures.

Ms. LEHNHARD. We agree.

Mr. STARK. What about the numbers? Is Blue Cross making a statement on the numbers?

Ms. LEHNHARD. I agree that the best hope of slowing the rate of increase is to move to the——

Mr. STARK. Do you think we can hit $452 billion in cuts over the next 7 years?

Ms. LEHNHARD. We are not qualified to answer that.

Mr. STARK. Thank you.

Chairman THOMAS. Does the gentleman from Iowa wish to inquire?

Mr. GANSKE. Thank you, Mr. Chairman.

Dr. Bristow, earlier in the hearing there were some rather unkind class warfare type of comments, and I am going to be very kind to you because I am not going to ask you to comment on the

fact that congressional salaries place Congressmen in the upper 5 percent, and I am certainly not going to ask you to comment about congressional pensions.

Dr. BRISTOW. Thank you.

Mr. GANSKE. I would like to ask you and Mr. Sprenger a question about provider antitrust, because I see a relationship developing in the PHO area. Have your organizations worked together to address some of the areas where we could correct some of the antitrust provisions that are limiting this area? Have you found any common ground?

Dr. BRISTOW. We have had discussions between the two organizations and we are attempting to find common ground. I do not think we are prepared at this time to try to report on that, but the discussions are ongoing.

Mr. GANSKE. I would very much appreciate it if both of you could provide me with specific language on areas in the code related to antitrust that are preventing increased competition in this area.

I want to move really to the subject of the hearing, which is standards of care, and I would like to ask Mr. Walworth and Ms. Lehnhard if they would care to enter into this.

You both cautioned the Subcommittees against enacting laws which would frustrate the ability of managed care plans to control costs, and I certainly agree with that, but you did not specify exactly what fell into this category. So let me ask you about a few specific proposals and you tell me if these proposals are "antimanaged care."

Would it be antimanaged care to establish and maintain a sufficient number and geographic spread of providers to ensure that all covered services are accessible to each enrollee in a reasonably prompt manner?

Mr. WALWORTH. From my perspective, not at all. I think it is the issue of what goes into those numbers. You will find in most HMOs, particularly under State law, that there are requirements and guidelines under the Federal HMO requirements, as well, that guide access to care, and these become measurements of that access to care.

Mr. GANSKE. Ms. Lehnhard, would it be antimanaged care to ensure a prompt or timely authorization of payment for emergency medical care?

Ms. LEHNHARD. No, and I would make the comment on all three of these that Medicare standards currently for risk contract address all of these and NCQA gets into a great deal of detail of looking at these. For example, Medicare has a 30-minute drive time rule on certain types of providers, so there are extensive standards in all these areas already.

Mr. GANSKE. Let me specifically ask you, because I have stayed in emergency rooms and waited for extended periods of time to get authorizations for managed care to go ahead with treatment. Would you think it was reasonable, if you placed a call through a managed care organization and you have not received a reply within say 30 or 40 minutes that you could proceed with treatment, and then expect payment? Ms. Lehnhard.

Ms. LEHNHARD. I hesitate to comment on that specifically. I do not know what the rules are in the accreditation process. There are

rules for these things and it is a question in some cases of enforcing those rules, just like under the basic program.

Mr. GANSKE. That it would not be unreasonable to have something related to that issue?

Ms. LEHNHARD. I do not know about specific times, but treatment in emergency rooms is definitely part of both the current Medicare and accreditation process standards.

Mr. GANSKE. Thank you so much.

Chairman THOMAS. Thank you.

Does the gentleman from Florida, the Chairman of the Subcommittee on Health, wish to inquire?

Chairman BILIRAKIS. Yes, Mr. Chairman. Thank you.

Mr. Sprenger, just one specific question to you and then maybe a general one to particularly Dr. Bristow, plus a couple of the others of you.

Mr. Sprenger, in your written testimony—of course, you mentioned this in your oral testimony, too—you talked about the provider sponsored networks which, generally speaking, frankly I think are a good idea. But you said that Medicare should take advantage of the innovations and efficiencies offered by PSNs by joining them in risk-sharing arrangements. Under such risk-sharing arrangements, PSNs would be paid on a partial capitation basis, but the risk assumed by the PSN would be limited, and that is when you referred to the fact they should be regulated somewhat differently. But that is another question and I am not going to go into that.

But who would assume the risks? That is the key thing. Basically, my question is, Who would assume the risks that the PSN is not subject to? Are we expecting that the beneficiaries would be liable in any way whatsoever?

Mr. SPRENGER. No, Medicare now goes under the fee-for-service system. You basically are an insurance company and you bear the risk for that. What we are suggesting is, for instance—and I am sorry Congressman Burr is not here, but his question about that quarter of the risk reward—right now, provider groups have such arrangements with HMOs, with Blue Cross and other organizations, where we take a certain portion of the risk, as well as the reward in managing care efficiently and effectively.

What we are suggesting is that if we are going to make major strides of moving managed care into the Medicare population to depend upon just where there are licensed HMOs in order to have that kind of risk-reward kind of sharing arrangement, that is why we are suggesting that there be an opportunity for provider groups to work directly with Medicare. We have communities where the 50–50 rules do not work, and the 5,000 minimum does not work. We have some rural communities where we can start moving into managed care and that is that direct relationship we think should be done.

Chairman BILIRAKIS. That is fine, but why should there be a partial compensation basis?

Mr. SPRENGER. Otherwise we need to get licensed as a full HMO, if we are going to take on the full risk.

Chairman BILIRAKIS. But this is all part of the overall picture, is it not, that AMA has made certain recommendations?

Mr. SPRENGER. That is correct.

Chairman BILIRAKIS. But if you did not have to go through the onerous regulations of trying to get the proper approvals and licenses, and so forth, is there any reason why you should be partially capitated?

Mr. SPRENGER. No. I think that with provider groups, you are going to limit it, though, with a number of provider groups that are prepared today to go at full risk. When you deal with populations all over the country, they are just not all ready to take on that full risk, and I think this is a transition period we are talking about and that we ought to start moving some of those managed care principles as quickly as we can as choices in the population——

Chairman BILIRAKIS. Dr. Bristow, in the AMA red booklet, you suggested this sort of thing, but were you thinking partial capitation?

Dr. BRISTOW. We were thinking that physicians should not be required to put up the same amount of reserves an insurance company has at risk because of the fact that physicians do have some capability of providing the services should the bank run dry, so to speak. But they also obviously have the opportunity to purchase reinsurance to back up the risk taking that they do assume through other entities. We believe that those are all viable ways in which provider groups could accept the risk and move on.

Our problem is that the way the current antitrust laws are written, they were written for a different time, and we do not want physicians to be exempted from the antitrust laws. We simply want the sort of accommodation that will allow them to compete in today's market in a realistic way.

Chairman BILIRAKIS. Well, all right. My time is about to expire, and I for one want to make the Korean memorial dedication because I am a Korean veteran. And I know we have another panel to go, so I am just going to yield back the balance of my time, Mr. Chairman. But I am very curious about how we should measure, how we are measuring physician performance and any recommendations on how that should maybe better be done, so possibly I give unanimous consent for Dr. Bristow and the others to submit that information to the Subcommittees.

Thank you very much.

Chairman THOMAS. Does the gentleman from Ohio wish to inquire?

Mr. BROWN. Thank you, Mr. Chairman. Thank you for holding this joint hearing to both Subcommittee Chairs.

I am concerned about the standards for managed care, and I do not want to be characterized as antimanaged care, but I am concerned about the standards. I look at something as scary, if you will, as the drive-through deliveries, that term that has been bandied about, where some insurance companies have basically pushed women that have just had children out of the hospital after one night's stay in order to save money, and demonstrating the extent to which your health insurance plans are intruding into medical practice. I know that physicians are concerned about that. Dr. Ganske mentioned that a moment ago, just that physicians' practices tend more and more to be dictated to by insurance companies.

Dr. Bristow, in your testimony you state that choice is at the heart of your proposal. I also note that the AMA supports allowing physicians to charge Medicare beneficiaries the amount that they want above what Medicare will pay. If the majority of Medicare beneficiaries are making less than $25,000 a year, how can they afford these extra charges? Increasing the fee-for-service cost, how does that increase choice for those people that cannot afford to go beyond what they are paying now?

Dr. BRISTOW. Well, the AMA proposal calls for full payment of the premiums for those who are below 100 percent of poverty and for partial payment of premiums on a sliding scale for those up to 150 percent of the poverty level.

We also have a longstanding existing policy within the AMA calling upon physicians to accept whatever Medicare sets as the payment for service for anyone who is below 200 percent of poverty. So that we do not believe that the low-income individual is going to be hurt by our proposal for those reasons.

We also feel, however, that there are opportunities, even with a low-income individual, to provide positive incentives for them to be cost conscious. If there is a way in which particularly the low-income individual can make a judgment as to whether or not to go to the emergency room with a cold or wait until tomorrow and go and see the doctor in his office with this same cold, and there is a possibility that at the end of the year he may get a few hundred dollars from his refundable deductible, that is all that we are trying to encourage: the use of judgment in obtaining health care services.

We think that is going to have a very salutary effect, and as you have seen from our physician paper, the red book, Price Waterhouse thinks that that would amount to a substantial savings over the course of 7 years.

Mr. BROWN. Well, certainly understanding in the case of someone that is home and is sick but probably not sick enough to go to the emergency room and makes that decision based on costs that might accrue to them, that they may have to pay out of pocket to wait until tomorrow to do that, that is not the case every time, obviously. The patient is not really making those cost decisions much because the patient is relying on the physician.

How do we cut $270 billion from Medicare as proposed in the House with Medicare paying less to doctors—presumably paying less to doctors—and find a way that senior citizens are not going to have higher copayments, higher deductibles, higher premiums? How is that going to happen?

Dr. BRISTOW. Well, the proposal that we have put forward suggests that using the incentive of cost consciousness and individual responsibility on the part of the beneficiary, plus making physicians more price sensitive by making their cost of services available to patients is a combination that we think will work effectively in terms of ameliorating the rate of increase of cost at the present time.

Mr. BROWN. The average senior citizen making $25,000 a year pays about 20 percent out of pocket right now for health care costs. That number can go up. That is not price sensitive enough?

Dr. BRISTOW. Well, what Price Waterhouse says, Congressman, is that of the entire spectrum of Medicare patients, 40 percent of them will actually pay less out of pocket with the proposal we have made, 50 percent will pay the same out of pocket with the proposal we have made, and 10 percent will actually pay more, most of those being the high-income elderly.

Mr. BROWN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Does the gentleman from Texas wish to inquire?

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Ms. Lehnhard, I want to ask you a few questions regarding the existing requirements for Medicare capitated programs listed in your statement. I want to ask you if these requirements that are outlined in section 1876 of the Social Security Act, if Blue Cross & Blue Shield has any feeling or opinion whether these standards are sufficient to protect consumer interests.

Ms. LEHNHARD. Yes, we think they are sufficient, and they have done a very good job of protecting the Medicare enrollees in the current HMO risk contracts.

Mr. LAUGHLIN. Then I want to ask, it is my understanding these standards were written some 10 years ago, and would you agree that the medical marketplace has changed significantly in the last 10 years? And if you agree with that, do you have an opinion as to whether the Subcommittees should reevaluate these standards to determine if they sufficiently reflect the current managed care practices? I refer you to your statement where in section 1876(c)(5), you state that it "allows members who are dissatisfied with the outcome of the grievance procedures to submit unresolved disputes to an appeal to the Secretary and to seek judicial review." As I read that, that would require me to go back and tell my senior citizens that if they have a grievance, they have got to find a Federal bureaucrat to take their complaint to.

Ms. LEHNHARD. First of all, I would definitely urge that the Subcommittees review these standards to be sure you are comfortable with them. Second, I think these standards are backed up by pages and pages, hundreds of pages of regulation that change frequently. And that is the beauty of these standards, is that they are broad and they do allow regulatory interpretation to keep up with the market.

In terms of the people having to go to the Secretary, I think it is very appropriate to have the Secretary available as a last resort on some types of—and I can very quickly get out of my depth here—on some types of appeals. But, again, Medicare and TQA require the health plan itself to have a series of appeals available to consumers. Whether or not the Secretary is the last step in the appeal process would be up to the Committees.

Mr. LAUGHLIN. Well, I want to continue with those standards and ask you: Who enforces these standards at the current time?

Ms. LEHNHARD. Right now I believe—and I look to other people here—HCFA does.

Mr. LAUGHLIN. That is my understanding also.

Ms. LEHNHARD. I do not think that there is any deeming in any of the——

Mr. LAUGHLIN. I next want to ask you, once an HMO is certified as meeting the section 1876 requirement, who reviews and evaluates them to be sure the requirements are being met?

Ms. LEHNHARD. That would be HCFA's responsibility.

Mr. LAUGHLIN. That is all I have, Mr. Chairman.

Thank you very much.

Chairman THOMAS. Thank you.

I will kind of divide the four of you into two groups, and I want to ask a series of questions so I can understand either the similarities or the differences.

Dr. Bristow and Mr. Sprenger, what you seem to be saying, a little bit in terms of your desire to do the partial risk with HCFA, is that it might be easier for people to understand an analogy between a farmer and a city folk, and that when you are dealing with food, the city folk have to buy it so they need more money, and the farmers do not need as much money because they grow the food and they can eat it. You folks are saying you are the providers, and so you do not have to pay for part of it; you can provide it yourself, and so you ought to be able to create a structure where you do not have the same profile. The farmer should not have to have the same cash reserves as the city folk because insurance companies would have to buy the services that you folks have contained in the structures.

Is that basically the point you folks are making about your structures?

Dr. BRISTOW. I think that is a very good homey way of expressing it, and I think it does a good job.

Chairman THOMAS. Well, I thought it was rather sophisticated, but that is OK. [Laughter.]

Mr. SPRENGER. Congressman, I would go one step further. We are not advocating that if we were going to take on the full risk that we should not meet all the requirements that apply to HMO. If we are going to change the rules, it ought to be a level playingfield, and the rules ought to change for an HMO as well as for those who take full risk.

I think the important thing for us is: Why aren't more enrolled in HMO plans today? If we are going to——

Chairman THOMAS. I understand your point, but you understand our concerns that it looks like we are creating a privileged group who get to pick and choose a little bit. So that is why I want to pursue some questions to understand it.

In the red book from the AMA, they do describe a profile, which is a Physicians Coordinated Care Organization, or something like that. Is that basically in your understanding, Doctor or Mr. Sprenger, the same thing you are talking about in terms of the integrated networks? Are we talking basically about the same thing?

Mr. SPRENGER. In terms of an integrated network, we are including all components.

Chairman THOMAS. So that would be similar to what? So you folks are both focusing on the same concept, with the understanding that Medicare would be the fall-back risk responsibility of last resort. And it occurred to me in trying to think through that model, would HCFA as an entity meet the standards that we currently apply to folk to carry out that full risk, any of you?

Mr. WALWORTH. If I may, Mr. Chairman, I think that the proposals that you have heard for partial capitation significantly alter the role of the Federal Government as the administrator, because it suggests that they are going to do something remarkably different than they have been historically doing—that is, really overseeing, operationally, the payment of claims on a fee-for-service basis.

Now you are getting into them being part of a process in which they have delegated to someone else the responsibility for managing care toward a target, but they are going to be holding the dollars.

Chairman THOMAS. What is part of my concern, we are taking a culture that is locked into a particular arrangement and assuming that in a relatively short period of time, or almost instantaneously, they turn into a different kind of a structure. It is an interesting idea. I think we ought to take a look at it because, clearly, it does get us in the field faster. But I think, Mr. Walworth and Mr. Sprenger, one of the problems I have is that I fall back on HCFA and I look at them and I just do not see somebody there who is ready to assume those kinds of responsibilities.

Now, the other side, I want to ask you folks, obviously Blue Cross & Blue Shield is in a lot of places. Do you have some real problems in terms of trying to meet State standards that are different? Do you see a broad range of standards out there that make you folks different in different States significantly?

Ms. LEHNHARD. Well, we are regulated differently in different States. We have supported a level playingfield, but in some States we are regulated much like the rest of the industry, in some States we are regulated as the carrier of last resort.

Chairman THOMAS. Well, have you found that in some States the standards that you have to meet are pretty much the same or higher than the Federal standards?

Ms. LEHNHARD. I think those types of standards you are talking about are unique to the private sector. They have to do with rates in a small group market, enrollment practices in the individual markets. They do not overlap with the Medicare standards.

Chairman THOMAS. But what I have heard here from a number of folks is that when, in fact, they do overlap, the private sector standards are oftentimes higher than the Federal standards, and that as a matter of fact, some organizations that have met the Federal standards flunk the private sector standard.

Ms. LEHNHARD. I know in California there are some unique issues that I am really not qualified to address.

Chairman THOMAS. Well, my concern is—and I was going to use California as another homey example—that in air quality standards, California is higher than the Federal standards, and that one of the difficulties we have now is that we cannot get the Feds and the State together because on the way to meeting the State standards, they meet the Federal standards, but the Feds will not allow certification for the Federal standards in trying to meet the State standards. So instead of pursuing one level which is higher than the other, you wind up having to meet two different standards, which, in fact, you met in a portion of the other one. I am just scared to death that if we try to build up a very heavy, top-heavy bureaucratic standard structure, make HCFA better in that regard,

we are not only going to not do as good a job as the private sector is doing, but create in a State-Federal structure here duplication that is not only needless but probably does not do the job we thought it was going to do.

My time has expired, and I want to thank this panel very much.

Chairman BILIRAKIS [presiding]. I would ask the next panel to come forward now, if they would, please.

Dr. Richard V. Aghababian, chairman of the Department of Emergency Medicine, University of Massachusetts Medical Center, Worcester, Massachusetts, on behalf of the American College of Emergency Physicians, and he is accompanied by Dr. David S. Davis, who is the attending physician in North Arundel Hospital, Glen Burnie, Maryland.

And we have Dr. Peggy M. Connerton, director of Public Policy, Service Employees International Union.

As per usual, your written statement is made a part of the record, and we would ask you to do the best you could to try to stay as close to the 5-minute rule as you might be able to.

We will start off with Dr. Aghababian. Did I mess that name up too badly?

Dr. AGHABABIAN. No. You have done quite well, sir. Thank you. I appreciate that.

Chairman BILIRAKIS. With a name like mine, I should do well.

**STATEMENT OF RICHARD V. AGHABABIAN, M.D., CHAIRMAN, DEPARTMENT OF EMERGENCY MEDICINE, UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER, WORCESTER, MASSACHUSETTS; ON BEHALF OF AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; ACCOMPANIED BY DAVID S. DAVIS, M.D. ATTENDING PHYSICIAN, NORTH ARUNDEL HOSPITAL, GLEN BURNIE, MARYLAND**

Dr. AGHABABIAN. Chairman Thomas, Chairman Bilirakis, I am Dr. Richard Aghababian, president of the American College of Emergency Physicians, a practicing emergency physician, and chairman of the Department of Emergency Medicine at the University of Massachusetts.

In 1992, 12.5 million of all emergency department visits in the United States were made by patients over the age of 65. Yet, today, emergency medical services are the single set of medical services most subject to payment disputes involving Medicare HMO enrollees. Nowhere is there a greater need for standards to protect seniors than in the area of emergency medical services.

The magnitude of this problem first surfaced in 1992 when a study commissioned by HCFA revealed that 40 percent of the coverage disputes involved "in-area" emergency services and an additional 20 percent of coverage disputes involved "out-of-area" urgent care services. The study's author described emergency services as "dispute prone."

Senior citizens in the emergency department setting are particularly challenging because their symptoms are often complicated and, therefore, diagnosis may be difficult.

Let me quickly review a case for you which exemplifies this problem. A 71-year-old male was admitted to the emergency department with vague chest discomfort and general malaise. He had suf-

fered a heart attack 2 years before. However, his blood pressure and pulse were normal, and the initial cardiogram did not indicate a heart attack.

The primary care physician denied authorization and advised that the patient be discharged home. It was the decision of the emergency physician to hold the patient in the emergency department for further observation. The old record indicated the patient had had similar vague symptoms before his prior attack and that he had not visited the emergency department since that previous episode. One hour later, while being observed in the emergency department, the patient went into cardiopulmonary arrest. Fortunately, he was successfully resuscitated in the emergency department.

This case demonstrates clearly that a telephone consultation is not a substitute for a physical examination. We have to remember that some patients are more stoic than others and react differently than other patients when they experience pain or frightening symptoms. This is why it is so critical to consider the patient's own experience when evaluating the urgency of the patient's condition.

As noted, the crux of the problem with regard to Medicare involves the definition of emergency medical condition.

HCFA's current definition places emphasis on the ability to judge the risk of permanent damage to the patient's health if treatment is denied. This is an issue that even qualified physicians might disagree on. Perhaps of greater importance for patients is a lack of any mention of the patient's subjective experience or symptoms as a legitimate reason to seek emergency medical services.

The college has advocated that a prudent layperson definition of emergency medical care be adopted for all health care plans, including the Medicare Program. This definition was first adopted by the State of Maryland in 1993 and has since been adopted in Virginia and Arkansas. The Maryland statute is also the core component of H.R. 2011, the Access to Emergency Medical Services Act of 1995, which has been introduced by Representative Ben Cardin of Maryland. Representative Stark has also included this definition in his bill, H.R. 1707.

The adoption of the prudent layperson definition will not take away the managed care plan's ability to review these cases. It simply directs that the focus of the review should be appropriately on the patient's presenting symptoms and whether, from a lay perspective, the patient acted prudently.

It is important to point out that emergency medicine is the only specialty that is required by Federal statute to treat all comers regardless of their ability to pay. Under section 1867 of the Social Security Act, emergency physicians and hospital emergency departments must provide a medical examination and treatment to stabilize the patient.

Increasingly, emergency physicians are being pressured by managed care plans to transfer patients to other plan hospitals or to discharge patients for economic reasons against the advice of the treating physician. Under H.R. 2011, plans would be required to provide coverage of emergency medical services regardless of whether they had a contractual arrangement with the hospital or emergency physician providing the care. In addition, plans would

be required to cover all services necessary to fulfill the requirements of section 1867 of the Social Security Act, including paying for the federally mandated screening examination.

Plans today routinely deny payment for emergency medical services if the patient did not obtain prior authorization. Coverage is frequently denied for emergency services simply because the patient was unable to reach the primary care physician. In many instances, these denials are issued regardless of the patient's condition and regardless of whether the primary care physician was available. Most plans do not have 24-hour-a-day, 7-day-a-week access to persons who are capable of making prior authorization determinations, as are required. In other cases, payment for services is denied even though the plan enrollee was referred to the hospital emergency department by the patient's primary care physician. Today plans are also trying to discourage the use of 911 emergency telephone numbers. Under H.R. 2011, these practices would be prohibited. The college urges the Subcommittees to adopt the provisions set out in H.R. 2011 as standards for the Medicare Program.

In closing, I want to emphasize that our overriding concern is the safety and well-being of the patients we encounter every day.

Thank you, sir.

[The prepared statement and attachments follow:]

**STATEMENT OF RICHARD V. AGHABABIAN, M.D.**
**UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER**
**ON BEHALF OF AMERICAN COLLEGE OF EMERGENCY PHYSICIANS**

Chairman Thomas and Chairman Bilirakis, I am Dr. Richard V. Aghababian, President of the American College of Emergency Physicians (ACEP), a practicing emergency physician and Chairman of the Department of Emergency Medicine at the University of Massachusetts Medical Center in Worcester, Massachusetts. I appreciate the opportunity to be here today to testify on behalf of the nearly 18,000 emergency physicians who are members of ACEP.

The purpose of this hearing is to explore and discuss the need for standards for private health insurance plans which seek to provide health care coverage to beneficiaries under the Medicare program. No where is there a greater need for standards to protect seniors than in the area of emergency medical services.

In 1992, the last year for which we have reliable statistics, 14 percent (approximately 12.5 million) of all emergency department visits in the United States were made by patients over the age of 65. The emergency department evaluation of senior citizens is especially challenging because atypical symptoms of specific ailments are masked or altered. Yet, today, under the existing Medicare program for participating Health Maintenance Organizations (HMOs), retrospective denial of payment for legitimate emergency medical services provided to seniors is common. In fact, emergency medical services are the single set of medical services most subject to payment disputes involving Medicare HMO plan enrollees.

The magnitude of this problem first surfaced in 1992 when a study commissioned by the Health Care Financing Administration (HCFA) revealed that 40 percent of the coverage disputes involved "in-area" emergency services and an additional 20 percent of coverage disputes involved "out-of-area" urgent care services. The study's authors described emergency services as "dispute prone." According to the study's authors, HCFA's statutory definition of emergency places beneficiaries in the "unreasonable position of making quasi-clinical evaluations of their symptoms and conditions and do not, expressly, make allowances for subjective experience (e.g., pain or suffering)." The authors of the study went on to say that "As a consequence, enrollees who appear to act prudently from a lay perspective may face substantial or even catastrophic out-of-pocket liabilities."

The HCFA data tracks and verifies the College's own findings, based upon the hundreds of case examples provided by emergency physicians of denials of emergency medical services by managed care plans over the last several months. The problem, we are afraid, is even more significant in the private sector where there is not a public reporting mechanism.

Just this past week, ACEP was presented with several case examples of the kind of denials being experienced by patients today. This case was presented to us by Marcus Martin, M.D., FACEP, an emergency physician in Pittsburgh, Pennsylvania. Dr. Martin provides this case example –

> A 20 year old female presented to the emergency department complaining of lower abdominal pain and heavy vaginal bleeding. She was sexually active and not using birth control. Her primary care physician denied authorization for emergency department care and sent her to a medical clinic where she was diagnosed with Pelvic Inflammatory Disease and treated with Doxycycline without a pelvic exam or pregnancy test being performed. One week later, she returned to the emergency department complaining of severe suprapubic pain. The onset was one hour prior to arrival. She was again denied authorization for emergency department services but was seen in the emergency department anyway and had a positive pregnancy test. An ultrasound showed no intrauterine pregnancy. Gynecology was consulted and the patient was taken to the operating room for laparoscopy and resection of ruptured ectopic pregnancy.

These are the kind of cases that emergency physicians are witnessing everyday with private pay patients enrolled in managed care plans. Our concerns for senior citizens are even more profound because we know that seniors are more difficult to diagnose because their symptoms are often atypical and are masked or altered. The following example is an actual case from my own hospital emergency department within the last two weeks.

> The senior resident on duty sees a 71 year old male who had presented to the hospital emergency department with vague chest discomfort and general malaise. This patient had suffered a heart attack two years previously. However, his blood pressure and pulse were normal and the initial electrocardiogram did not indicate a heart attack. After consulting with the attending emergency physician, the senior resident called the patient's primary care physician to request authorization to admit the patient for observation. The primary care physician denied authorization and advised that the patient should be discharged home with appropriate follow-up home care. Despite the primary care physicians directive, the senior resident held the patient in the emergency department for continued observation. In the meantime, the medical record of the patient was obtained from the previous admission for the patient's earlier heart attack. It was determined that the patient had presented to the emergency department at that time with the same vague or atypical symptoms. One hour later, while still being observed, the patient went into cardio-pulmonary arrest due to a fatal heart rhythm. Fortunately, the patient was successfully resuscitated in the emergency department with no damage to his vital functions.

This case demonstrates clearly that a telephone consultation is not a substitute for a physical examination. The art of medicine is listening to the patient, observing the patient, and synthesizing all of the information that you have before you and based upon your education and previous experience, making an assessment of what should be done for the patient. A critical part of this process is observing the patient closely and listening carefully. We have to remember that some patients are more stoic than others and react differently

than other patients to their pain and general symptoms. This is why it is so critical to consider the patient's own experience.

As noted, the crux of the problem with regard to Medicare involves the definition of an emergency medical condition. HCFA's current statutory definition (Attachment 1) defines emergency services as services that:

(1) are furnished by an appropriate source other than the HMO or CMP;

(2) are needed immediately because of an injury or sudden illness; and

(3) cannot be delayed for the time required to reach the HMO or CMP providers or suppliers without risk of permanent damage to the patient's health.

HCFA's current definition places emphasis on the ability to judge the risk of permanent damage to the patient's health if treatment is delayed. This is an issue that even qualified physicians might disagree upon. Perhaps of greater importance for patients is the lack of any mention of the patient's subjective experience or symptoms as a legitimate reason to seek emergency medical care services. A central premise of emergency medicine is that emergency medical conditions occur unpredictably and usually involve a sudden onset of symptoms. The patient's subjective assessment of the severity of his symptoms is central to the patient's decision to seek emergency medical services. The definition of an emergency and the payment determinations that result from that definition should clearly take into account a prudent layperson's assessment of the severity of his symptoms. This is, after all, the information that a treating physician would use to focus his medical evaluation.

The problem with "after-the-fact" denials is that they ignore the patient's presenting symptoms, which is the reason patients go to the emergency department in the first place, and base the payment decision on the patient's final diagnosis. For example, a middle-aged male presents to the hospital emergency department with a chief complaint of chest pain. Only an appropriate medical evaluation by a qualified physician can determine whether the patient is having a heart attack or whether it is a less serious condition. Clearly a medical evaluation is appropriate if the symptoms are of sufficient severity to the patient to prompt the patient to seek emergency medical services. The important fact is that the patient's subjective experience is the principle patient determinate of whether to seek emergency medical services. You cannot eliminate the patient's subjective experience. It is a critical source of information upon which to base your medical examination.

According to the Centers for Disease Control, the number one complaint of people presenting to the emergency department is abdominal pain. Again, the abdominal pain can indicate many different conditions with varying degrees of severity. It could be very serious conditions such as cholecystitis, appendicitis, pancreatitis, ectopic pregnancy, dissection of the aorta or it could be less serious conditions such as gastroenteritis, a urinary tract infection or constipation. The

problem is that on the front end you simply don't know whether it's serious or non-urgent.

The College has advocated that a prudent layperson definition of emergency be adopted for all health care plans, including the Medicare program. The College's proposed definition says –

> "Emergency health care services are those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

This definition was first adopted by the State of Maryland in 1993. Since 1993, the prudent layperson definition has been adopted in Virginia and Arkansas. The Maryland statute is also the core component of H.R. 2011, The Access to Emergency Medical Services Act of 1995 which has been introduced by Rep. Ben Cardin of Maryland, who, as you know, is a member of the Ways and Means Health Subcommittee. The College wishes to thank Rep. Cardin for the introduction of this important legislation and his leadership on this issue. The College would also like to thank Rep. Stark for the inclusion of this definition in his bill, H.R. 1707.

The following Emergency Medical Service and consumer advocacy organizations have endorsed H.R. 2011: the Emergency Nurses Association, the Coalition for American Trauma Care, the National Association of EMS Physicians, the EMS Section of the International Association of Fire Chiefs, the International Association of Firefighters, the American Ambulance Association, Public Citizen, Citizen Action and Consumer's Union.

The Cardin legislation would codify HCFA's current payment guidelines (Attachment 2) to HMOs on the coverage of emergency medical services. HCFA's guidelines say to HMOs that emergency services "must be, or appear to be, needed immediately." HCFA's guidelines go on to say "There does not need to be threat to a patient's life." "Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature." With these guidelines in effect, why, you may ask, do we need legislation? There are two reasons.

> (1) Despite the laudable efforts of HCFA to persuade the HMOs to provide appropriate coverage of emergency medical services, as recently as March of this year, Dr. Rodney Armsted, Director of the Office of Managed Care, issued an official reminder (Attachment 3) to the Medicare participating HMOs reminding them of their responsibility to cover emergency medical services. In short, the guidelines have had some impact, but HCFA continues to review a disproportionate number of emergency care cases. These reviews are time consuming and costly.

HCFA only reviews those cases that were not decided in favor of the beneficiary after an initial plan appeal.

(2) The statute and HCFA's guidelines are clearly inconsistent. It is not clear whether HCFA can enforce its guidelines if contested. In the 1992 study of HMO claim denials for emergency services conducted for HCFA, the authors' recommended that "Definitions of 'emergency' in regulation should be modified so that a reasonable and prudent layperson can anticipate claims that would be covered versus denied."

The enactment of the prudent layperson standard for the Medicare program would be an important first step in protecting Medicare beneficiaries from being inappropriately denied access to emergency medical services. The effect of adopting the definition would be to shift the focus of any disputed service from a review of the patient's discharge diagnosis to a review of the patient's presenting symptoms. The adoption of this definition does not take away the managed care plan's ability to review these cases. It simply directs that the focus of the review should be appropriately on the patient's presenting symptoms and whether, from a lay perspective, the patient acted prudently.

It is important to point out that emergency physicians and hospital emergency departments do not enjoy the luxury of being able to second-guess patients about the severity of their symptoms or provide "eye-ball" diagnosis when patients walk in the door of the hospital emergency department. Emergency physicians are the only medical specialty that is required by federal law to treat all comers regardless of their ability to pay. Under Section 1867 of the Social Security Act, emergency physicians and hospital emergency departments must provide an appropriate medical screening evaluation to determine whether the patient is having a medical emergency and provide appropriate treatment to stabilize the patient. Violations of the COBRA statute can result in civil monetary penalties of up to $50,000.

Increasingly, emergency physicians are being pressured by managed care plans to transfer patients to plan hospitals or to discharge patients for economic reasons and against the advice of the treating physicians. Under H.R. 2011, plans should be required to provide coverage of emergency medical services regardless of whether they have a contractual arrangement with the hospital or emergency physician providing the emergency care to the plan enrollee. In addition, plans would be required to cover all services necessary to fulfill the requirements of Section 1867 of the Social Security Act, including payment for the federally mandated medical screening evaluation.

Plans today routinely deny payment for emergency medical services if the patient did not obtain prior authorization to go to seek care in the emergency department. Coverage is frequently denied for emergency services simply because the patient was unable to reach the patient's primary care physician. In many instances, these denials are issued regardless of the patient's condition and regardless of whether the primary care physician was available. In many cases today, plans still do not have 24 hour, seven day a week access to the persons who are capable of making prior authorization determinations required by the

plan. In other cases, payment for services are denied even though the plan enrollee was referred to the hospital emergency department by the patient's primary care physician. Today plans are also trying to discourage the use of the 911 emergency telephone number. Under H.R. 2011, these practices would be prohibited. The College urges the Committee to adopt the provisions set out in H.R. 2011 as standards for the Medicare program.

In conclusion, Chairman Thomas and Chairman Bilirakis, the College would like to thank both of you and the Members of the Ways and Means and Commerce Health Subcommittees for this opportunity to testify today on an issue of great importance to the emergency physicians of this country. In closing, I want to emphasize that our overriding concern is the health and safety of the patients we encounter everyday. Patients who believe they are experiencing a medical emergency should not delay seeking treatment because they are uncertain whether those services will be covered. Thank you for allowing me to testify today.

## Subparts G through I—[Reserved]

## Subpart J—Qualifying Conditions for Medicare Contracts

[¶ 20,896J.400]

**§ 417.400 Basis and scope.**

(a) *Statutory basis.* The regulations in this subpart implement section 1876 of the Act which is added by section 114 of Pub. L. 97-248. Section 1876 of the Act authorizes Medicare payments to HMOs and competitive medical plans (CMPs) through contracts under which the HMOs and CMPs are reimbursed for furnishing covered services to Medicare beneficiaries.

(b) *Scope.* This subpart sets forth the requirements an entity must meet in order to enter into a contract with HCFA as an HMO or CMP to be reimbursed, through capitation payments, for services furnished to Medicare beneficiaries who are enrolled with the HMO or CMP. Subparts N, O, and P set forth the principles that apply for each of the two methods for reimbursing HMOs and CMPs: reimbursement on a risk basis and reimbursement on a reasonable cost basis.

**.01 Source:**

As adopted, 50 FR 1314 (Jan. 10, 1985, effective Feb. 1, 1985), and amended at 58 FR 38062 (July 15, 1993), and at 59 FR 49834 (Sept. 30, 1994).

[¶ 20,896J.401]

**§ 417.401 Definitions.**

As used in this subpart, and Subparts K through R of this part, unless the context indicates otherwise—

*Adjusted average per capita cost* (AAPCC) means an actuarial estimate made by HCFA in advance of an HMO's or CMP's contract period that represents what the average per capita cost to the Medicare program would be for each class of the HMO's or CMP's Medicare enrollees if they had received covered services other than through the HMO or CMP in the same geographic area or in a similar area.

*Adjusted community rate* (ACR) is the equivalent of the premium that a risk HMO or CMP would have charged to Medicare enrollees independently of Medicare payments using the same rates as charged to non-Medicare enrollees if the benefit package was limited to covered Medicare services.

*Arrangement or arrangements* means a written agreement executed between an HMO or CMP and another entity in which the other entity agrees to furnish specified services to Medicare enrollees of the HMO or CMP, but the HMO or CMP retains responsibility for those services. Under an arrangement, Medicare payment to the HMO or CMP discharges the beneficiary's obligation to pay for the service.

*Benefit stabilization fund* means a fund established by HCFA at the request of an HMO or CMP with a new risk contract to withhold a portion of the per capita payments available to the HMO or CMP for payment in a subsequent contract period for the purpose of stabilizing fluctuations in the availability of the additional benefits provided by the HMO or CMP to its Medicare enrollees.

*Demonstration project* means a demonstration project under section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1) or section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b-1 (note)), relating to the provision of services for which payment is made under Medicare on a prospectively determined basis.

*Emergency services* means covered inpatient or outpatient services that—

(1) Are furnished by an appropriate source other than the HMO or CMP;

(2) Are needed immediately because of an injury or sudden illness; and

(3) Cannot be delayed for the time required to reach the HMO's or CMP's providers or suppliers (or alternatives authorized by the HMO or CMP) without risk of permanent damage to the patient's health.

These services are considered to be emergency services as long as transfer of the enrollee to the HMO's or CMP's source of health care or designated alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance involved in the transfer and the nature of the medical condition.

*Geographic area* means the area found by HCFA to be the area within which the HMO or CMP furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

*Medicare enrollee* means an individual who is entitled to Medicare benefits (Part A and Part B or Part B only) and who has been identified on HCFA records as an enrollee of an HMO or CMP that has a contract under section 1876 of the Act.

*New Medicare enrollee* means a Medicare enrollee who—

(1) Enrolls with an HMO or CMP after the date on which the HMO or CMP first enters into a risk contract under subpart L of this part;

- Physician assistants (see MCM § 5259);
- Nurse practitioners (see MCM § 2156) *;
- Clinical nurse specialists *;
- Nurse midwives (see MCM § 2138); and
- Certified registered nurse anesthetists (see MCM § 5261).

See § 2153.4 for a discussion of the coverage of auxiliary personnel when furnished without physician supervision.

* Section 4155 of the Omnibus Budget Reconciliation Act of 1990 amended coverage of nurse practitioners in rural areas and added coverage of clinical nurse specialists effective January 1, 1991.

B. *Transplants.*—You are required to cover organ and tissue transplants that the Secretary determines are not experimental. Required transplants include:

- Kidney (see CIM § § 35-35, 35-58, 45-22, and 50-26 [¶ 27,201]);
- Heart (see CIM § 35-87);
- Liver (see CIM § 35-53);
- Bone marrow (see CIM § 35-30); and
- Cornea.

You are required to provide or arrange for certain transplants in out-of-area hospitals. Heart and liver transplants may only be performed in Medicare approved transplant centers. Not all hospitals performing transplants are Medicare approved transplant centers, even if they are participating hospitals for other services.

If one of your Medicare enrollees is a candidate for heart or liver transplant surgery, give him/her written notification that the procedure is a covered Medicare service and that it is performed in facilities approved by Medicare. The transplant facility makes the determination as to whether the enrollee meets the patient selection criteria. Refer your enrollees who are appropriate candidates only to Medicare approved heart or liver transplant facilities for evaluation. HCFA notifies you of each new Medicare approved transplant facility. The Regional Office (RO) has a complete list of these facilities. The facility determines whether to perform the transplant. Failure to refer appropriate candidates to, or to provide or arrange for the service in, a Medicare approved heart or liver transplant center is subject to a civil money penalty of up to $25,000 for each violation.

C. *Midyear Coverage Changes.*—As benefits become covered, they must be made available to Medicare enrollees on the effective date of Medicare coverage. The cost of providing new or expanded benefits which are mandated by Congress midyear must be borne in its entirety by contracting risk HMOs and CMPs. However, when the Secretary expands benefits which the Secretary identifies as involving significant costs, and these benefits were not included in the adjusted average per capita cost (AAPCC) calculation, risk-based HMOs and CMPs are not responsible for providing or paying for these benefits. When HMO/CMP enrollees receive such services, Medicare pays the benefits under fee-for-service until the next contract year, when the benefits are included in the AAPCC.

*HMO/CMP Manual* § 2102 (as revised by Trans. 9, Jan. 1992).

The Secretary is required to study the availability of covered chiropractic services in HMOs and present its findings to the congressional committees no later than January 1, 1993 (¶ 17,805).

Sec. 4204 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). [A summary of the law was originally reported at NEW DEVELOPMENTS ¶ 38,951.]

.22 **Emergency and urgently needed services.**—HCFA guidelines state as follows:

Emergency Services

Assure that medically necessary emergency care is available 24 hours a day, 7 days a week. Beneficiaries are not required to receive emergency services at your plan facilities nor are they required to secure prior approval for emergency services provided inside or outside your geographic area. Provide a system to pay claims for emergency services provided out-of-plan and pay for all emergency services provided out-of-plan. (See § 2107 [¶ 13,960.35] for the permissible limits on the amount you must pay.)

*Definition.*—Use the definition provided in 42 CFR 417.401. Specifically, "emergency services" mean covered inpatient and outpatient services that are:

- Furnished by an appropriate source other than the organization;
- Needed immediately because of an injury or sudden illness; and
- Needed because the time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health. Such services must be, or appear to be, needed immediately.

*Example:* While visiting her son, a 70 year old woman with a history of cardiac arrhythmias experiences a rapid onset of chest pain, nonproductive hacky cough, and generalized tired feeling. The son calls his own physician, who recommends he bring his mother in to see him right away. After the physician evaluates the patient, the physician diagnosis is a common cold, and he prescribes two over-the-counter medications for treatment.

In this case, the HMO/CMP is required to pay for the physician's services because the enrollee's

medical condition appeared to require immediate medical services.

There does not need to be threat to a patient's life. An emergency is determined at the time a service is delivered. Do not require prior authorization. You may request notification within 48 hours of an emergency admission or as soon thereafter as medically reasonable. However, payment may not be denied if notification is not received.

If it is clearly a case of routine illness where the patient's medical condition never was, or never appeared to be, an emergency as defined above, then you are not responsible for payment of claims for the services. Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. An example is a member who is treated in an emergency room for chest pain and the attending physician orders diagnostic pulmonary angiography as part of the evaluation. Upon retrospective review, you cannot decide that the angiography was unnecessary and refuse to cover this service.

If during treatment for an emergency situation, the enrollee receives care for an unrelated problem, you are not responsible for the care provided for this unrelated non-emergency problem. An example is a member who is treated for a fracture and the attending physician also treates a skin lesion. You are not responsible for any costs, such as biopsy, associated with treatment of this unrelated non-emergency care.

After the emergency, pay the cost of medically necessary follow-up care. (See § 2105.)

*Transfers.*—If one of your Medicare enrollees receives emergency medical care in a non-plan hospital, you may wish to transfer the patient to your facility (or a facility that you designate) as soon as possible. Pay the transfer costs, such as an ambulance charge, if it is necessary.

Be aware that the transferring hospital is subject to statutory limitations on when, and how, the transfer may be made. Under § 1867 of the Act, the hospital must first determine whether the patient's condition has stabilized within the meaning of the statute. In general, this means that within reasonable medical probability, no material deterioration of the condition is likely to result from, or occur during, the transfer.

If the patient's condition has not stabilized, the patient may only be transferred if the patient makes an informed, written request for transfer, or the attending physician or appropriate medical authority signs a certification that the risks of the transfer are outweighed by the medical benefits expected from transfer to another medical facility. If these conditions are met, then the transfer may be made, but only if it also meets the definition of an appropriate transfer. (See § 1867(c)(2) of the Act.)

In general terms, an appropriate transfer is one in which:

- The transferring hospital:

—Provides medical treatment to minimize the risks to the individual,

—Forwards all relevant medical records, and

—Uses qualified personnel and transportation equipment for the transfer;

- The receiving facility:

—Has available space and qualified personnel, and

—Except for specialized facilities that under § 1867(g) of the Act cannot refuse a transfer, agrees to accept the transfer and provide appropriate medical treatment; and

- The transfer meets any other requirements the Secretary may find necessary in the interest of health and safety of individuals.

If the transferring hospital fails to meet these requirements, it may lose its Medicare provider agreement or be subject to civil money penalties or a civil action for damages. Physicians involved in an improper transfer may also be subject to civil money penalties and may be excluded from participation in Medicare.

Provide assistance with the above requirements to facilitate an appropriate transfer to one of your facilities or a facility that you designate.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the HMO/CMP.

*HMO/CMP Manual* § 2104 (as revised by Trans. 9, Jan. 1992).

Urgently Needed Services

Urgently needed services are Medicare covered services required in order to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or an injury. Cover these services if:

- The enrollee is temporarily absent from your geographic area, and

- The receipt of health care services cannot be delayed until the enrollee returns to your organization's geographic area. The enrollee is not required to return to the service area because of the urgently needed services.

Attachment 3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Managed Care
Washington, D.C. 20201

MAR 27 [illegible]

TO: CURRENT MEDICARE-CONTRACTING HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SUBJECT: FINANCIAL RESPONSIBILITY FOR EMERGENCY SERVICES

Dear Sir/Madam:

As a result of complaints received regarding access to emergency services in managed care, we are sending this letter to remind all Medicare-contracting HMOs and CMPs of policies relating to the provision of emergency services for Medicare beneficiaries.

The enclosed document (Operational Policy Letter 95-5) references regulatory and HMO/CMP manual citations relating to emergency services.

Sincerely,

Rodney C. Armstead

Rodney C. Armstead, M.D.
Director

FASS System

Enclosure

Office of Managed Care
Operational Policy Letter 95-5

**Issue:**

Policies relating to the provision of emergency services for Medicare beneficiaries.

**Policy:**

Federal regulations at Title 42 Part 417.414(c)(1) state:

> An HMO or CMP must assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services (as defined in § 417.401) that are obtained by its Medicare enrollees from providers and suppliers outside the HMO or CMP even in the absence of the HMO's or CMP's prior approval. [Emphasis added].

Therefore, Medicare-contracting managed care plans cannot require prior authorization for emergency services. This policy is also stated in section 2104 of the HMO/CMP manual: "Do not require prior authorization."

In addition, section 2104 of the HMO/CMP manual states "Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature." Therefore, if emergency services appeared to be needed, plans may not decide upon retrospective review to refuse to cover emergency services provided.

Refer to section 2104 of the HMO/CMP manual for further detail on Medicare policies relating to emergency services.

**Contact Person:**

Anne Manley, Office of Managed Care, (202) 619-3166

Mr. BURR [presiding]. I thank you, Doctor.

At this time, the Chair would recognize Dr. Davis.

Dr. DAVIS. Thank you, Mr. Chairman. I am here at the invitation of Congressman Cardin to answer any questions you might have about the experience in Maryland where we have had similar legislation in place for the last 2 years.

Mr. BURR. I apologize to you, Doctor. The Chair was not paying attention. If you could repeat your question?

Dr. DAVIS. Certainly. I am here to answer any questions about the experience we have had in Maryland where this legislation has been in effect since 1993.

Mr. BURR. Doctor, do you have any formal testimony that you would like to make or any comments other than just taking questions?

Dr. DAVIS. I would say that it has not increased at all any inappropriate use of emergency services, and it has not raised the cost to the HMOs. It may have decreased costs by allowing fewer costly hospital admissions.

The Maryland Association of HMOs has now deemed this law to be prudent public policy even though they opposed it 2 years ago.

Mr. BURR. Dr. Davis, I appreciate that.

At this time, the Chair would recognize Dr. Connerton.

**STATEMENT OF PEGGY M. CONNERTON, PH.D., DIRECTOR OF PUBLIC POLICY, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL–CIO, CLC**

Ms. CONNERTON. Thank you, Mr. Chairman. I am here on behalf of the 1.1 million members of SEIU, the Service Employees International Union, and I would like to provide this afternoon the perspective of the private sector on the current state of the art on monitoring quality and where we need to go in the future.

Let me say at the outset that SEIU strongly supports reforms that will improve the program's efficiency and effectiveness and ensure its ability to provide benefits over the long term. Indeed, many of the private sector innovations that policymakers are currently considering incorporating in the Medicare Program, such as managed care, selective contracting, broader use of centers of excellence, and case management, were, in fact, pioneered by labor unions and their employers over the last two decades.

Our written testimony addresses the labor movement's deep concern with the unprecedented magnitude of the cuts and outlines the principles against which we will judge overall Medicare reform.

There are two principles that are really relevant for today's topic. The first is the issue of choice. SEIU believes that Medicare beneficiaries should have access to the same range of mainstream health care coverage options available to working Americans. And in bargaining with our employers, SEIU has tried to ensure that a wide range of choices are, in fact, available to our members.

The second principle that is relevant to today's hearing is that health plans and providers who would provide services to Medicare beneficiaries must be able to meet rigorous quality standards.

Now, while labor and management have had success in getting costs under control, particularly in recent years, we often know very little about the quality of the product that we are buying.

I recently attended a meeting of the Jackson Hole group that brought together purchasers of health care from both sides of the bargaining table, as well as the public sector, including HCFA.

The purchasers at this meeting expressed the concern that they were having tremendous success in pushing down prices, but were unsure of what the impact was on the quality of care. This is exactly the same kind of discussion that took place earlier this morning about whether or not cost cuts of this magnitude will or will not affect quality of care for Medicare beneficiaries.

From SEIU's perspective, we have been finding more complaints about managed care from our members as these integrated delivery systems become tighter and hence more restrictive. And, indeed, our health care membership has reported dangerous reductions in staffing levels, increased patient falls, high medication errors in hospitals, and other signs that this price-driven competition may be threatening the quality of patient care.

Purchasers at the Jackson Hole meeting seemed to have concluded that report cards based on process measures like NCQA were, while helpful, not particularly useful in comparing different health plans. Purchasers also expressed the frustration about the strong resistance of health plans and providers to providing standardized information on quality that could be used to compare health plans.

It is clear that the incentives in the private sector market are today very much weighted toward competition based on price and not on quality.

With this in mind, I would like to say that there are several principles that we have been using in the private sector that we think are important to helping make health plans more accountable for their performance. The first is in the area of access to high-quality care.

NCQA and other kinds of private accrediting groups simply track the word "access" by looking at the percentage of members who visited a plan provider within the past 3 years. Now, this obviously is not an adequate measure of access of services, which includes things like convenience and location, hours of operation, and accommodation of participants with special needs.

There is also a very important interest in getting patient satisfaction surveys, and it would be important that Medicare regularly survey beneficiaries on their use and satisfaction about their health plans.

The third area is consumer rights, which, in fact, most of the private purchasers do not address at all. It really is a State-by-State function, and that is the whole question of consumer rights. In a managed care environment, public disclosure and other protections for consumers are vitally important, yet on the State level there are very few requirements by most of the State health departments other than that a plan has to have a grievance procedure in effect.

In short, there are not particularly good protections at the State level today in the HMOs to assure that grievance procedures and everything else are addressed. This would be particularly important in the case of our most vulnerable populations, the Medicare beneficiaries.

The fourth principle, of course, comes down to monitoring quality. This is something I think that is extremely important that both the private and the public sectors need to collaborate on. It is not a problem which is unique to the Medicare population. It is a problem that the private sector is confronting across the board. As I said earlier, we still have no good measures by which consumers can judge the quality and the performance of health plans. It is important that health plans provide the data on some health outcomes measures, and that is the direction that the private sector is heading.

However, I just simply need to point out that this is an issue that is at its infancy, and so the idea of putting 37 million Medicare beneficiaries into private health plans in the next several years is simply unrealistic. In fact, given that the private sector has not yet figured out how to monitor quality at this time, I think that would be a very dangerous move.

Mr. BURR. Doctor, I am going to ask you to summarize as quickly as you can, please.

Ms. CONNERTON. I am finished.

[The prepared statement follows:]

TESTIMONY OF

DR. PEGGY M. CONNERTON
DIRECTOR OF PUBLIC POLICY

SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

BEFORE THE

SUBCOMMITTEES ON HEALTH
COMMITTEES ON WAYS AND MEANS AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

JULY 27, 1995

Mr. Chairman, members of the Committee, I am Peggy Connerton, Director of Public Policy for the Service Employees International Union, AFL-CIO, CLC. With over 1.1 million members, SEIU is the third largest union in the AFL-CIO and the fastest growing. SEIU members work in both the public and private sectors and include 450,000 health care workers who work in acute care hospitals, nursing homes, mental hospitals and other health care facilities. On their behalf, I would like to thank the chairman and the other members of the subcommittee for this opportunity to testify today about the future of the Medicare program.

In three days we will mark the 30th anniversary of the creation of Medicare, signed into law by President Lyndon Johnson on July 30, 1965. It is often forgotten that at that time, only half of America's elderly had any health insurance. Millions of elderly Americans lived with the fear that a serious illness could rob them of both their health and their retirement savings.

Today, Medicare pays the doctor and hospital bills of more than 37 million Americans. At a time when the ideas of public purpose and activist government are under attack, Medicare stands as a shining example of how a well-run government program can make a difference in the lives of working families. The program's success is reflected in support that extends across generations. A recent poll conducted by the Daniel Yankelovich Group found that nine out of ten Americans under the age of 65 (including 87 percent of those aged 18 to 29) want Medicare to be there when they retire.

This support for Medicare among younger workers should not be surprising. Medicare is the linchpin of our nation's system of retirement health security. Rapidly rising health care costs have led many employers to drastically scale back their coverage for retirees or eliminate it entirely. Future retirees will be even more dependent on Medicare than current retirees.

In many ways, Medicare is more efficient and effective than private sector health plans. Medicare spends only 2 percent of program costs on administration, less than health plans serving large private employers (5.5%) or small private employers (25%). From 1976 through 1991, the rate of growth in per enrollee costs for Medicare was equal to or even below that of private sector plans. Since 1991, the rate of growth in per enrollee costs for Medicare and private health plans has been roughly equal and this is expected to continue over the next few years. Most of the program's projected growth over the next ten to twenty years comes from increases in the number of eligible individuals because of the aging of the baby boomers.

SEIU does not dispute that the Medicare's current rate of growth of 10 percent a year is unsustainable. We do not object to reforms that will improve the program's efficiency and effectiveness and ensure its ability to provide benefits over the long term. Our position has always been that the rapid increase in Medicare program costs over the last several years mirrors the health care cost crisis in the private sector. What is needed is *system-wide* cost control that should be implemented as part of a comprehensive health care reform program that provides universal health insurance coverage to all Americans.

The labor movement knows a great deal about the problem of rising health care costs. Over the last decade, health care has been the number one issue at the bargaining table. While disagreements over health care issues have made collective bargaining more contentious than it otherwise would have been, labor and management have also worked together to pioneer new cost containment strategies. Indeed, many of the private sector innovations that policymakers want to incorporate into the Medicare program, such as managed care, selective contracting, use of centers of excellence and case management, were pioneered by the labor unions and employers over the last decade.

While we are committed to participating in a discussion about how to strengthen the Medicare program for the 21st century, that is not what the debate so far in Congress has been about. It seems clear to us that what happened is that the budget resolution conferees estimated how much they needed to cut from Medicare in order to meet their arbitrary seven-year target for balancing the budget and provide a staggering $245 billion tax cut to wealthy vested interests. The Medicare trustees report is merely an after the fact justification. How else are we to explain that the proposed cuts in Medicare are more than twice the level of what is needed to ensure the adequacy of the trust fund for at least the next ten years.

If we are going to make changes to Medicare, we need to move cautiously and carefully. The goal must be to strengthen the program, not simply to reach an arbitrary budget target or to provide $245 billion in tax cuts for the rich and large corporations. A recent poll by the Kaiser Family Foundation found that this position is shared by most of the public. In that survey, only 28 percent of the public supports major reductions in Medicare if the goal is to provide a tax cut.

In the remainder of my testimony, I want to outline the principles that SEIU believes should guide policymakers as they consider changes to the Medicare program. Finally, I will examine a number of the proposed policy options in light of those principles.

**Principles for Medicare Reform**

When he put forward the original Medicare legislation in 1961, President Kennedy explicitly linked his proposed health insurance program for the elderly to Social Security and Unemployment Insurance, noting:

> "Twenty-six years ago this Nation adopted the principle that every member of the labor force and his family should be insured against the haunting fear of loss of income caused by retirement, death or unemployment...But there remains a significant gap that denies to all but those with the highest incomes a full measure of security--the high cost of ill health in old age."

With these words in mind, let me outline the principles that SEIU is using to judge any proposed changes to the Medicare program.

- **Universality:** The Medicare program must retain the system where all Americans contribute to the program during their working years and are eligible for the program's benefits when they reach 65 or become disabled.

- **Defined Benefits:** Medicare reform must not lead to any reductions in the scope of benefits that are currently covered.

- **Limits on Premium Share:** Medicare currently pays 100 percent of the Part A "premium" and 75 percent of the Part B premium. Medicare must retain its commitment to pay a certain percentage of a beneficiary's premium and should not limit its premium payment to a flat amount.

- **Choice:** Medicare beneficiaries should be able to obtain coverage from the same range of mainstream health care coverage options that millions of working men and women rely

on, including HMOs, PPOs, and Point-of-Service plans, in addition to the traditional indemnity coverage offered by the Medicare program. Medicare beneficiaries must be able to maintain existing relationships with primary and specialist providers.

- **Quality Standards:** Plans and providers who would provide services to Medicare beneficiaries must be able to meet rigorous quality standards. Providers and plans should be required to report clinical outcomes and this information should be made available to Medicare beneficiaries.

- **Limits on Out-of-Pocket Costs:** Medicare reform must be consistent with the program's original intent of keeping beneficiaries' out-of-pocket payments for health care services within a manageable level. Higher costs should not be used as a bludgeon to force beneficiaries into lower cost plans.

- **Public Accountability:** The debate over the future of Medicare cannot be conducted behind closed doors. It must be a public debate that involves all stakeholders, with a sufficient period of time for research and reflection on the various options. The debate thus far has not conformed to this model.

**Evaluating Proposals for Medicare Reform**

One of the difficulties in assessing the impact of proposed Medicare reforms is that the Congress has not yet provided the public with a detailed proposal. Instead, as I noted earlier, the budget conferees selected a number designed to help meet an arbitrary goal of balancing the budget by the year 2002 and providing a $245 billion tax cut to the wealthy. Although we are looking forward to examining the Committee's legislation in detail, SEIU wishes to offer comments on some of the proposals that have been floated during the past few weeks.

***Increased Premium and Cost Sharing for Medicare Beneficiaries***

One proposal that has been put forward is to impose higher premiums for Medicare Part B. In 1990, Congress set the Medicare Part B premium in actual dollar amounts in order to protect beneficiaries from rapidly rising health care costs. But program costs have actually risen more slowly than expected, so beneficiaries are currently paying 31 percent of program costs. Some have suggested making this arrangement permanent, and pegging Part B premiums at 31 percent of program costs.

SEIU members have been down this road before. Over the last ten to fifteen years, employers attempted to reduce their benefit costs by shifting more of the burden to workers. Forcing workers to pay more, however, did nothing to reduce the rate of growth of health care costs.

We are concerned that the result will be the same in this case. Medicare beneficiaries, almost two-thirds of whom have incomes less than $15,000, will be forced to pay higher and higher premiums as Medicare costs continue to spiral upward. Cost shifting should not be confused with cost-control.

Another idea that has been put forward is to impose a new, income-related premium for higher-income beneficiaries. Since, however, 97 percent of Medicare beneficiaries (including couples) earn less than $50,000 a year, the only way that this proposal would raise any revenue would be to set the income threshold quite low. This would hurt millions of low and moderate-income retirees.

Still another revenue raising option that has been proposed is to add 20 percent coinsurance payments for Home Health services, Skilled Nursing Facility care, and laboratory services. While this would raise out-of-pocket costs for beneficiaries, it might not save the Medicare program any money, as beneficiaries might spend additional days in the more

expensive hospital instead of opting for lower cost care in an SNF or at home.

***Deep Cuts in Reimbursement to Providers***

This is an old Medicare standby and has the potential to generate considerable savings for the program--at an enormous cost. A recent analysis conducted by Lewin-VHI for the American Hospital Association suggested that cutting Medicare by $250 billion could lead to hospital payment rates that are more than 20 percent below costs. Hospitals and other providers would be forced to make up their losses by increasing the rates they charge private pay patients. This would raise the cost of health insurance for millions of working families and lead even more employers to drop coverage.

A 1991 study by Lewin-VHI for the National Association of Manufacturers confirmed the existence of cost shifting, finding that the private sector was already paying close to $11 billion more a year because of underpayment by public programs. The Medicare cuts proposed in the budget resolution are the largest ever considered--several times greater than the $57 billion Congress enacted in 1993. Even if enhanced market competition prevents providers from shifting all of the cuts to private payers, cuts of this magnitude will certainly lead to a significant increase in private health insurance costs. To the extent that providers are unable to shift costs, they will be forced to cut services.

It has been suggested that Congress could avoid this problem if it encouraged more beneficiaries to enroll in managed care plans. But this merely leads to a different set of problems. Since no one seriously believes that the federal government can save $250 billion by moving beneficiaries into these kind of programs, there would still be a need for payment reductions in order to meet the budget targets. But reducing capitation rates to managed care plans will merely reduce the number of managed care plans that want to enroll Medicare beneficiaries, reducing access.

SEIU members work on the front lines of patient care in hospitals, skilled nursing facilities, home care agencies, and other settings. We know first hand what happens to patients when Medicare makes large cuts in reimbursement. Providers begin to cut corners in staffing and look for ways to get people out of the facility earlier--in many cases before they are truly ready to be discharged. The kind of drastic Medicare cuts outlined in the budget resolution will have a negative effect on the quality of care in facilities across the country.

*Managed Care*

SEIU has supported--and continues to support--allowing Medicare beneficiaries to have a choice of plans that includes health maintenance organizations (HMOs) and other proven managed care entities along with the traditional Medicare fee-for-service plan. In bargaining with our employers, SEIU has tried to ensure that these choices are available to our membership.

However, it would be foolhardy to see managed care as a panacea for the program's cost problem. The truth is that the managed care industry has little experience in serving large numbers of retirees. Given that the magnitude of cost savings associated with managed care for those under the age of 65 is still in dispute, it will be some time before we can come to any definite conclusions about whether Medicare managed care can save money.

There are also special difficulties associated with treating the elderly and disabled. difficulties that many managed care plan may not be prepared for. Those retirees who are enrolled in managed care tend to be younger, on average, than Medicare beneficiaries as a whole. As an individual ages, the development of an established relationship with a physician who is aware of a their medical history becomes much more important, as does access to specialized services. HMOs usually try to limit the use of specialist care and, in some cases, they may not even have an ongoing relationship with certain types of specialist providers.

***Vouchers***

One of the proposals that has received a great deal of attention is the idea of giving Medicare beneficiaries "vouchers" that they would use to purchase private health insurance. The voucher would be set at a flat dollar amount and would be adjusted every year by an inflation factor set at roughly half of the program's current rate of growth. Beneficiaries would then be free to enroll in any health plan, but would have to pay the difference between the amount of the voucher and the cost of the plan.

While supporters of this plan argue that it would give Medicare beneficiaries greater choice, the truth is that it would resort to financial coercion in order to force beneficiaries into low cost health plans. Millions of retirees would watch helplessly as the value of their vouchers failed to keep pace with the cost of their health insurance.

In order to escape large annual increases in their premium costs, retirees would be forced to shift continually into cheaper plans. This would disrupt their established relationships with primary and specialist providers and put their health at greater risk. The continued movement of a large group of elderly, less healthy individuals into different health plans creates the potential for instability in the system.

SEIU's experience with the CalPERS system, which provides health and retirement benefits to over 100,000 of our members in California, highlights some of the problems. Retirees tend to cluster in plans that give them greater choice of provider, driving up the price of these plans and causing younger and healthier individuals to leave, which drives up the price even higher. While CalPERS has been successful in negotiating rate reductions in 1995-96 of over 5 percent for its HMO plans, the premium for PERSCare (a PPO plan with a large number of retirees) increased by five percent.

Similar problems could result if Congress decides to push Medicare beneficiaries into the Federal Employees Health Benefit Plan (FEHBP). If beneficiaries choose to cluster in a few plans because they provide better choices of providers, those plans could quickly be swamped with more claim activity than they can handle. They may move to restrict provider choices in order to discourage Medicare beneficiaries from joining. Some plans may even go bankrupt. In either case, the quality of care for both federal employees and Medicare beneficiaries will decline.

The potential of Medicare recipients to destabilize a prepaid health plan would likely lead to discrimination against them, either in enrollment or in treatment. Although it is likely that any Medicare reform legislation will require plans to enroll anyone who applies, the history of antidiscrimination legislation suggests some discriminatory practices can escape the definition of the law. A more significant problem is likely to be discrimination in treatment, where the elderly are denied access to clearly beneficial care that is extremely costly. A 1991 study of California HMOs by the Medicare Advocacy Project concluded that "Medicare beneficiaries are extremely vulnerable to misleading marketing by HMOs," and that those who enroll in HMOs "have few meaningful appeal rights" if they disagree with a physician about seeing a specialist.

Because of the potential for discrimination, it is very important that quality standards be developed and that plans be required to report their clinical outcomes. But outcomes and quality research is still in its infancy and it is likely to be several years before we have a workable system that can gain the support of all stakeholders. Large purchasers such as CalPERS have only succeeded in getting premium costs under control. They are just starting the process of trying to evaluating the level of quality they are getting for their money, and they would be the first to tell you that they are a long way off from knowing anything more than just the basics.

While it may be heresy to suggest this in a time of fiscal austerity, Congress needs to consider spending *more* money on outcomes and quality research. The potential payoff in program savings down the road is significant, but only if the federal government is willing to

invest the necessary resources.

***Risk Contracts for Private Plan Sponsors***

One of the proposals that has been put forward is to allow unions, employers and other health plan sponsors to contract with Medicare to provide coverage for their retirees. The United Mine Workers, for example, has been doing this for several years and the results have been largely positive. SEIU locals across the country operate multiemployer trust funds that provide health and pension benefits to tens of thousands of SEIU members. Our locals are interested in the idea that they would be able to provide "one stop shopping" for all health care benefits for their members.

Financing is, of course, a key concern, both to the government and to the plans. In managing multiemployer plans, for example, the trustees are not running a business in which they are free to take big risks in the hope of achieving big gains. They are nothing more, and nothing less, than fiduciaries of a fund that must be administered in a way that maximizes the benefits of those it covers. Because Medicare has provided the lion's share of health coverage for the over-65 population for so long, multiemployer plans--like other private sector payors--do not have a reliable base of experience from which to estimate the potential cost of folding this age group back into their basic coverage. We are also concerned that the large cuts being contemplated in the Medicare program will require plan sponsors to assume unacceptable levels of risk in covering beneficiaries.

***Medical Savings Accounts***

Perhaps even more radical than the idea of using vouchers is a proposal to incorporate so-called Medical Savings Accounts into the Medicare system. Under this option, beneficiaries would be allowed the option of enrolling in a high deductible health plan and having the federal government make a contribution to a Medical Savings Account on their behalf. Money in the MSA could be used to pay medical expenses and, depending on how the plan is designed, any money left over at the end of the year can be rolled over into an interest bearing account for future expenses or spent for other purposes.

The principal problem with MSAs, as the Congressional Budget Office has recently noted, is that they exacerbate risk segmentation. In theory, healthier Medicare beneficiaries would tend to gravitate toward the MSAs, with less healthy individuals remaining in the traditional Medicare plan. If this happens, the MSA option is unlikely to save the Medicare program any money, and could actually increase the pressure on the trust fund. Medicare would be making MSA contributions on behalf of healthy individuals who might not need to use the money, and would be unable to use those funds (as it does now) to subsidize the care of the high cost patient that would remain in the traditional program.

***Changing the Medicare Eligibility Age***

It has been suggested that Medicare's age of eligibility be increased to track the increase in the Social Security age of eligibility for full benefits. Leaving aside the question of whether it was good policy to raise the Social Security age threshold, this proposal ignores significant differences between the two programs. While the majority of retirees have significant sources of retirement income other than Social Security, most rely almost entirely on Medicare to insure them for physician and hospital services. Given that the average age of retirement is actually falling--especially as many companies have downsized over the last few years--raising the age of eligibility could force millions of elderly Americans to go without health insurance for several years.

**Conclusion**

As I noted earlier, SEIU does not contest the fact that Medicare will require significant changes if it is to be able to cope with the retirement of the baby boomers. However, many of the changes that are currently under consideration pose hazards to beneficiaries--present and future. The cuts required by the budget resolution are so large as to call into question the ability of Medicare to provide its current package of benefits in any form for the money that the federal government will be paying.

Our members see Medicare and Social Security as woven together into a sturdy fabric that they depend on for their retirement security. If "reform" is merely a code word for shifting costs from the federal government to beneficiaries and the private sector, then that fabric will begin to unravel. One of our finest achievements as a nation over the past fifty years--the dramatic reduction in the number of elderly living in poverty--will be put at risk.

SEIU's experience in negotiating and managing health benefit plans in the private sector suggests that there are innovative, but less radical, steps that could turn Medicare from a passive payer of bills into an active purchaser. This is the way that most private plan sponsors are moving. Moving toward a strategy of active purchasing would strengthen the ability of the program to pay benefits for the next ten to fifteen years. This would give us ample time to explore options for more far reaching restructuring if it should become necessary. Reforms of this type could include:

- **Competitive purchasing** of standardized services and supplies, including durable medical equipment, laboratory testing, radiology and outpatient surgery.

- **Establishment of explicit quality and performance standards** and refusal to do business with providers who do not measure up. Medicare needs to move beyond the minimal participation requirements that are now set in legislation. New standards for providers should include the HEDIS-type "report card" and health outcomes measures for which the Medicare program would be accountable.

- **Development and use of centers of excellence and specialized services contracting.** Medicare now uses such concepts in its coverage for transplant services and private sector plans, including union-sponsored Taft-Hartleys, use selective contracting even more widely for many forms of surgery, cancer care, mental health and so forth. A policy of selective contracting, however, needs to take into account the wish of most Medicare beneficiaries to preserve relationships with existing providers.

- **Use of case management** of high cost patients. Most private-sector health plans have the flexibility to work with high-cost patients to develop service packages, such as home care, that can better meet their needs.

- **Improved enforcement** to address fraud and abuse. In recent testimony, a GAO official noted that the Medicare program is "overwhelmed" by fraud and abuse and that it is a "particularly rich environment for profiteers." Improved enforcement could yield tens of billions of dollars in savings a year.

In the end, the members of SEIU believe that reform of the Medicare system should be linked to reform of the whole health care system. For years, the private sector has been allowed to insure the young, the healthy, and the financially secure, whereas the public sector has been left with the job of insuring the elderly, the sick, and the poor. Although costs have risen for the private and public sectors alike, the burden of public sector programs has been especially heavy of late, and threatens to bankrupt federal, state, and local governments and drive costs even higher for working families. What is needed is *system-wide* cost control that should be implemented as part of a comprehensive health care reform program that provides universal health insurance coverage to all Americans.

Mr. BURR. Doctor, I thank you, and I thank all three. The Chair will exercise the option of the Chair to reverse the direction that we ask questions, which puts me first and last, since I happen to be the only one here. And I apologize for that, but there are a number of things going on on the Hill, as well as some key votes on the House floor and debates right now. But I can assure each of you that it is very valuable to have you in and to have your testimony, because what we are undertaking will probably be one of the most important decisions in my days here in Washington.

Dr. Aghababian—I make a good stab at it. I can say "Bilirakis." I have learned that. But I will have to practice yours a little bit. Let me start with you, if I could.

My health coverage is under an HMO and has been for a number of years. I come from North Carolina, which we are not supposed to know these things until last, but, in fact, this was something that we experienced very early on. There was a savings, and one of the things that you had to do was adjust to a new system. It was a choice for every individual at the company that I worked for.

Unfortunately, while on a vacation in Michigan, I got very ill, went directly to an emergency room. The emergency room never questioned the fact that I was an HMO patient, even though we presented a card, specifically covered it with them. They never stopped what they perceived to be a needed emergency treatment. Fortunately, in a couple of weeks, I was fine.

I guess I would only ask you from my personal experience, am I the exception or am I the norm?

Dr. AGHABABIAN. I can only tell you that on a given day we end up spending several hours on the telephone——

Mr. BURR. Move just a little closer to those mikes, if you could. I never believed it, but it is very difficult up here to hear you folks.

Dr. AGHABABIAN. Understanding that we have perhaps in my department nearly 200 encounters a day, I can tell you that there are several hours spent on the phone trying to get approval for various conditions.

Mr. BURR. I understand and certainly realize that the HMOs have asked all of us to do things a little bit differently. But I think that your testimony really dealt with the potential health of the individuals coming in. And what I would like to really determine: Is your concern with the health of the individuals and the quality of care that they are receiving, or the fact that in the emergency room we are having to shift to a different approval process than the decision by the attending physician, as has been the norm for several years?

Dr. AGHABABIAN. I would just like to begin by saying, Mr. Burr, I would hope that if you came to my emergency department you would have the same—I am sure you would have the same experience of not having your insurance in any way interact with our providing you with appropriate care. We would certainly want that to be the case.

However, I must go on to say that we deal with 30 or 40 different plans in my emergency department, each of which has different rules about payment. And much of what we experience occurs not only at the time of service but retroactively if they decide not to pay for the service. So that you may not have had a problem, and

we certainly would not interrupt the care of someone who we thought was very sick. But a month or two down the line, our hospital and the group that I work with at the university might not be paid for that service they rendered to you.

Mr. BURR. Well, let me ask this, if I could, Doctor. Given that you would not stop what you perceived to be an emergency, are, in fact, the ones that are questioned situations where the individual thought that the emergency room was the appropriate place, but had they placed a call or if a call was made when they walked in the door, that they would have, in fact, been directed to possibly another source?

Dr. AGHABABIAN. There are cases——

Mr. BURR. And I realize we are talking in very broad terms. We are not talking about specific cases. But I think we certainly have to understand the context of what happens daily.

Dr. AGHABABIAN. Right. It is our responsibility, because of the Social Security Act—and, of course, we are happy to do this—to provide an immediate screening exam. The patient who comes in with chest pain may have indigestion or may have a very serious condition, as the one I just described.

I was recently reviewing a case of a 6-month-old child whose parent called because the child was listless and had a fever of 104 and was advised to drive 42 miles to a plan hospital and en route had a cardiac arrest and, as a result of his blood-borne infection, had all four limbs amputated.

Now, how can you tell from the symptoms that a patient describes over the phone if they are having an emergency or not? That takes a lot of experience. So if someone comes to our department complaining of discomfort in the chest, we take it very seriously, and we do whatever has to be done to prepare for a complication that might occur. Then we worry about the health insurance implications.

But what happens is if someone comes with a laceration, which I could easily repair or could be repaired at a doctor's office, or a splinter that has to be removed from their heel that is causing them a great deal of pain, I could assess that problem, and we could try to access the plan, as we often will do. And they may or may not approve the payment for that service.

Now, we still offer the patient the opportunity to have it remedied by us and then to take up the issue of who is going to pay for it with their insurance company. We never delay care. We always take care of the people. But my staff and I will then be on the phone for hours on some cases that are more complex trying to get approval for it.

Now, it is not only approval to treat, but if we elect to admit someone, then we have to get approval to admit. So sometimes we have to make two or three calls to get approval to have a specialist see the patient. So we are constantly on the phone talking about plans, and often we are talking to a nurse or someone with no medical training about what we would like to do to a patient who has an urgent condition.

I would like to defer to Dr. Davis about his experience in Maryland.

Mr. BURR. Let me, if I could, just ask one question of you, though. As an emergency room physician, as one who constantly treats those who are either in an emergency situation or believe that they are, when you deal with seniors, do you find that seniors have a close connection with their primary doctor and, in fact, want notification to them very quickly that there is a problem?

Dr. AGHABABIAN. Not always. There are very stoic individuals who wait until the last minute before they go to the hospital with a symptom, will not call their doctor, who believe they do not want to bother their physician, and will be urged by a family member to come. Seniors are a very diverse lot, and I am glad that is the case. I had a 90-year-old come in with a heart attack recently, and when I was discussing with him the newest approaches of therapy which have risks, he said, "Go for it." He had suffered his heart attack while he was chopping a cord of wood. That is a 90-year-old man chronologically who is physiologically much younger.

I think age is a relevant term these days, and certainly the way they behave to symptoms is very relevant.

Mr. BURR. Well, the individuals that have come before our Commerce Committee who have really opposed the injection of new options, and specifically managed care options, have done so with the contention that seniors are so close currently to their physician that the fear may be that their physician is not listed on that approved list.

One, let me take this opportunity to state that I believe whatever reforms come out of the 104th Congress will protect the existence of the current system for those that would like to stay on it. So I think the debate is about what options we provide, and since I have another Member who has entered the room, I am going to have to watch the clock on myself since I am already over, and I want to go over to Dr. Connerton because I want to go to your conclusion and just ask you a couple of questions, if I could.

I read from your concluding remarks,

> The cuts required by the budget resolution are so large as to call into question the ability of Medicare to provide its current package of benefits in any form for the money that the Federal Government will be paying.

Let me just ask you to define Medicare in that context. Is that HCFA?

Ms. CONNERTON. What?

Mr. BURR. In the sentence that I read where you state that this would "call into question the ability of Medicare to provide its current package of benefits in any form for the money that the Federal Government will be paying." In other words, we pay $4,800 per senior today. We are going to raise it to $6,700. I would assume from that statement that you are saying we cannot supply the same package from HCFA for $6,700 in the future.

Ms. CONNERTON. I think it is clear what we were talking about is the scale of the cut and the impact that that would have on the health delivery system as a whole.

Mr. BURR. Well, I realize that a lot of your statement dealt with the overhaul of the entire system.

Ms. CONNERTON. Yes.

Mr. BURR. I guess this would be a good time to ask you as a representative of your group. Did your group endorse the President's

plan last year? Would that have been—I note your reference to, "What is needed is a system-wide cost control that should be implemented as part of a comprehensive health care reform program that provides universal health insurance coverage to all Americans." That is, in fact, what the President offered last year. Was that a plan that you as a representative endorsed?

Ms. CONNERTON. The Clinton health plan was endorsed by all of the unions in the labor movement. That is correct, yes.

Mr. BURR. Very good.

All right. At this time the Chair will recognize Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. It is just amazing how fast your seniority has gone up. I guess if you sit here long enough, why, everyone else leaves.

I want to thank the panelists for staying so long. It is hard being on the third panel because the other ones go longer and you never know what time you are going to be needed, so you sit here the whole day. We appreciate your coming.

I want to reinforce the difficulties that managed care present in the emergency room. Certainly in the life-threatening situations, bound by the Hippocratic oath, we just take care of patients, period. You would agree with that?

Dr. AGHABABIAN. Absolutely, sir.

Mr. GANSKE. I think the quality of care issue arises when you have an acute situation but not a life-threatening situation; that is, a bad hand laceration or something like that. And I can relate from personal experience, because I participated in several HMOs, that the emergency room doctor will make an attempt to get the referring doctor, the primary care doctor on the line. Not infrequently, there is a long delay. So because you have got this bottleneck and you have got all these patients waiting out in the emergency room, you want to try to get these patients taken care of in a reasonable period of time.

You will then phone the specialist, a surgical specialist or whoever is necessary. Is that right?

Dr. AGHABABIAN. Yes.

Mr. GANSKE. And I think probably not infrequently you get an answer from that surgical specialist, well, I will be more than happy to come if you have received authorization. Is that right?

Dr. AGHABABIAN. That is correct.

Mr. GANSKE. The reason for that—correct me if I am wrong—is that if the specialist goes and takes care of the patient but he has not received an authorization from the gatekeeper, then he will receive no payment.

Dr. AGHABABIAN. He will also receive a lot of headache, besides not receiving payment.

Mr. GANSKE. Not only that, but the primary care doctor will get mad at him.

Dr. AGHABABIAN. Correct.

Mr. GANSKE. Because he has now initiated treatment and may not be the choice or on that panel for that particular HMO or PPO; is that right?

Dr. AGHABABIAN. That is correct.

Mr. GANSKE. So what happens? Basically, patients sit there for long periods of time.

Dr. AGHABABIAN. I can think of a classic example that you will appreciate. A middle-aged man came in recently to see me at the front desk; he had broken up a dog fight, and he had several puncture wounds on his hands that were bleeding and open lacerations. He was informed that his insurance company would have to be called. They were called and told the man that, for payment, he would have to go to an urgent care center where I knew on duty was a generalist who did not understand the complication of this injury. I told him that it would be better to be treated here, this was a serious problem. I even called the physician back, who again said, no, send the patient to the center that was manned by someone with minimal experience. It was with great reluctance, because it was the patient's choice, that I let that patient leave with a serious dog bite of both hands, knowing that the incidence of infection and complications could be quite high.

It was heartbreaking to me as a physician because I want to treat my patients as best I can.

Mr. GANSKE. I find it rather paradoxical that those patients that come into the emergency room that have no insurance—I mean, not even title XIX—they will get quicker care than those who have worked hard and have purchased a health insurance plan.

Dr. AGHABABIAN. In our institution, that man would have been seen by a hand or plastic surgeon.

Mr. GANSKE. Thank you very much for your testimony.

Mr. BURR. Thank you, Dr. Ganske.

The Chair would recognize Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Dr. Connerton, I would like to address a couple of things in your testimony, and I apologize if I repeat a couple things.

You mention in here about the $245 billion tax cut. Were you aware that the tax cut in the Contract With America was passed without touching Medicare? In other words, it was completely paid for without touching Medicare during the Contract With America. Were you aware of that?

Ms. CONNERTON. I am dealing with the present situation, which is the budget resolution.

Mr. ENSIGN. Were you aware, during the Contract With America, our tax cuts were completely 100 percent paid for without touching Medicare? Purposely without touching Medicare or Social Security?

Ms. CONNERTON. If you say so.

Mr. ENSIGN. Well, it is a matter of fact. It is not a question of anything I say. It is a matter of fact. During the Contract With America, we had 245 billion dollars' worth of tax cuts—actually, more than that—that we did without touching Medicare. We paid for them with cuts in other areas. We did it without touching Medicare.

I think that saying that our tax cuts are being paid for by Medicare or inferring that in your testimony, your written testimony, is very unfair.

Ms. CONNERTON. Well, all I can say is that I am dealing with the budget resolution. I know the Contract With America had some very back-of-the-envelope calculations in it, and I think what is relevant——

Mr. ENSIGN. Back of the envelope? These tax cuts were scored by CBO, and so were all of the spending cuts scored by CBO.

Ms. CONNERTON. Let me just repeat that what we are looking at here is a situation where there is an attempt to balance the Federal budget and achieve tax savings of $245 billion over the next——

Mr. ENSIGN. Correct. We actually had higher tax cuts during the Contract With America without touching Medicare. Repeat, without touching Medicare.

Now, after the Contract With America, the President's own trustees came out with a report that said Medicare will be bankrupt in the year 2002. The President's own trustees, after the Contract With America. After the tax cuts which were paid for without touching Medicare, without the budget proposal that we came out with, without trying to balance the budget, Medicare still goes broke, based on the President's budget that he sent up here that was not balanced in the year 2002. Medicare still goes broke.

Would you agree with that?

Ms. CONNERTON. I would agree that there is a long-term solvency problem with the Medicare Trust Fund.

Mr. ENSIGN. Even without a balanced budget, even without the tax cuts, Medicare still goes broke?

Ms. CONNERTON. That is the current projection. And you have to understand that in——

Mr. ENSIGN. So how can you——

Ms. CONNERTON. Wait——

Mr. ENSIGN. $245 billion in tax cuts to the fact that we are taking that out of Medicare when we did it without it?

Ms. CONNERTON. I am just going back to the arithmetic, and the arithmetic is that you want to balance the budget and achieve $245 billion in tax cuts, and in order to make that all happen, you want to take $270 billion out of the Medicare Program.

Mr. ENSIGN. OK. Let's go to some different line of questioning. Do your recipients have better coverage or worse coverage than Medicare recipients today, your enrollees?

Ms. CONNERTON. Well, we are a service workers union, so it is——

Mr. ENSIGN. On average.

Ms. CONNERTON. On average, I would say "yes" because we have stop loss insurance and prescription drug coverage, better mental health coverage, yes.

Mr. ENSIGN. OK. Why do you think that the private sector has been able to keep up with some of the newer coverages and yet Medicare has not? In other words, a lot of Medicare recipients are not receiving as good a coverage today as people in the private sector. You mentioned prescription drug coverage being a huge part of that.

Ms. CONNERTON. That is correct, but we pay for that as part of our compensation package. And, in fact, we have traded off pay increases in order to get additional benefits at the bargaining table.

Mr. ENSIGN. But even nonunion places are doing that. Even nonunion places without collective bargaining are doing that. I have experience in those areas as well, and even nonunion places—I have worked at union facilities and nonunion facilities, and non-

union places are doing that as well. So I think that we obviously know that, and the point I am making is that we need to improve, we need to provide more service for less money. Your union has been associated with a lot of companies that are doing that not only in their health care plans, but they are building better products for less money. They are providing better services for less money. We are capable of doing that because of better management techniques that your union has been associated with, and you have actually been integrally associated with that. You have seen that happen throughout the eighties, that American companies have become more competitive because of the cooperation and because of the systems that have been put in place.

This is what we are saying that we can do with Medicare, we will slow the rate of growth of spending in Medicare, not as a cut but through efficiency and through strengthening the system.

Ms. CONNERTON. Let me just repeat. My oral testimony really focused on the whole issue of monitoring quality. I mean, we have really been behind a lot of the innovative sort of private sector techniques, managing care. We believe in managed care and see it as a better way to achieve cost-effective care for our employees.

Mr. ENSIGN. Let me just ask one——

Ms. CONNERTON. At the same time—let me just finish what I am saying. At the same time, the private sector is very weak, and they would admit it, and the Jackson Hole meeting which I attended, the whole purpose of the discussion by the purchasers was we do not have a handle around quality at all. All the competition going on there in the marketplace, we are driving down the prices, but we do not know what is happening to the quality of health care that our employees are getting. That is basically where the private sector is at this point. We are a long ways away from determining whether a health plan is a good health plan or a bad——

Mr. ENSIGN. Mr. Chairman, if you will indulge me just for one last question. The savings that have been achieved in the private sector, large employers last year actually had their medical costs go down by about 1.1 percent. Would you classify—if I have a company and I am spending $3,000 on an employee this year, through efficiencies I am able to next year spend $2,900 an employee. Would you call that a cut or would you call that savings?

Ms. CONNERTON. It depends on what happens on the quality.

Mr. ENSIGN. Same quality. Same or maybe better.

Ms. CONNERTON. Well, the way that you have set up the question, the answer obviously would be you would not consider that a cut.

Mr. ENSIGN. If we were able to design a Medicare system, to design a system where we are spending $1,900 more a year per person, providing the same or better quality, would you consider those Medicare cuts?

Ms. CONNERTON. Again, the way the question has been set up, you know, which is the big "if," assuming everything else is constant——

Mr. ENSIGN. Sure, but we do not know that "if," do we?

Ms. CONNERTON. We do not know in the private sector whether we are getting value for our money. We do not know what we are getting.

Mr. ENSIGN. Even though when we do survey our employees——

Ms. CONNERTON. Even though we see cost savings——

Mr. ENSIGN. Even though when we survey our employees, they are every bit as happy or happier with their health care coverage now as before.

Ms. CONNERTON. Well, it is part of the whole question of looking at—if you want to look at the characteristics of the population as a whole or whether you focus your survey on sicker populations. That is one of the reasons why employers are very interested in getting information on health status, because how you view your health plan has a lot to do with your health status. Most employees probably do not use the health plan over the course of the year, but the 10 percent, 20 percent who do, who have the direct interactions with the physicians, with the hospitals and so forth, are the relevant group for interviewing on that end.

There is also the question of health outcomes. Ultimately, is a plan producing a good health outcome? We are very far away from the——

Mr. ENSIGN. I would agree with you there, and I would just encourage your organization to work with us, because Medicare is such an important system. So many people are so dependent on that. Obviously, a lot of your retirees are, and it is such an important system that we have to save it. So instead of just putting out political rhetoric that says that we are cutting Medicare, when, in fact, we may not be cutting Medicare, we may just be achieving cost savings and better quality.

Thank you, Mr. Chairman, for your indulgence.

Mr. BURR. The gentleman's time has expired.

Dr. Davis, I would like to bring you into this for just 1 minute, and I hope that, in fact, this is appropriate to ask you. You have heard part of the debate today. You are in health care. I think you understand the complexity of the issue that we are dealing with. Do you have any suggestions to the Subcommittees, either by what you have seen firsthand or items that you have seen within the medical community that would be prudent for the Subcommittees to look at very seriously that we have not had on the table today?

Dr. DAVIS. Yes, I do. Thank you. I do think that standards are important. I am not willing to turn the oversight over to the private companies. I think Government entities can do that just as well, if not better. I am glad to see the Federal Government taking an interest in this.

Mr. BURR. Well, I can assure you that we hear what you are describing to us. I can only tell you that by every analysis done by an agency of the Federal Government, GAO today—we have had other extensive hearings both in Ways and Means and in Commerce—it is not the opinion of those who do the surveys that, in fact, the Government performs as well as the private sector in this particular case. And HCFA's ability to replicate the successes of the private sector has been slow and sometimes off the mark.

Let me end this hearing today with just a little bit out of the trustees' report, if I may. I quote from the overview of the trustee's report on Medicare.

Under present law, as shown by the projections in this report, the Hospital Insurance Program costs are expected to far exceed revenues over the 75-year long-range period under any reasonable set of assumptions. As a result, the Hospital Insurance Program is severely out of financial balance, and the trustees believe that the Congress must take timely action to establish long-term financial stability for the program. With the magnitude of the projected actuarial deficit in the Hospital Insurance Program and the high probability that the Hospital Insurance Trust Fund will be exhausted in less than 11 years, the trustees urge the Congress to take additional actions designed to control Hospital Insurance Program costs and to address the projected financial imbalance in both the short range and the long range through specific program legislation as part of a broad-based health care reform. The trustees believe that prompt, effective, and decisive action is necessary.

I want to take the opportunity to thank all the doctors on this panel, to thank the other panels that preceded you, and to take this opportunity to thank the Subcommittee Members of Ways and Means and of the Commerce Committee. Congress is in a position to exert the responsibility that the trustees have asked us to do, and that is to investigate every option, to talk to everybody concerned—those that agree, those that disagree—to make sure that, in fact, we have the highest quality of health care delivery for our seniors in this country. I am certain over the next several months working with you and others who are willing to come and testify and share with us your feelings on that, in fact, we will reach something that assures all of us of a high quality of care for the seniors in America.

This hearing is now adjourned.

[Whereupon, at 2:27 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT

OF THE

AMERICAN ACADEMY OF NURSE PRACTITIONERS
AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
AMERICAN COLLEGE OF NURSE-MIDWIVES
AMERICAN COLLEGE OF NURSE PRACTITIONERS
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
AMERICAN PHYSICAL THERAPY ASSOCIATION
AMERICAN PODIATRIC MEDICAL ASSOCIATION
AMERICAN PSYCHOLOGICAL ASSOCIATION
AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION
NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN REPRODUCTIVE HEALTH

TO THE

HOUSE WAYS AND MEANS COMMITTEE
AND
HOUSE COMMERCE COMMITTEE

ON

JULY 27, 1995

The undersigned associations representing the interests of over 500,000 health professionals appreciate the opportunity to submit written testimony to the House Ways and Means and Commerce Committees to share our views on issues related to the health care delivery system. These non-MD health professional associations share the concern that all Americans should have the opportunity to obtain services from all types of health care providers who are licensed or certified to provide those services. Based on this concern, we would like to describe how this can be accomplished.

**RELATIONSHIP BETWEEN HEALTH PLANS AND HEALTH PROFESSIONALS**

Our associations believe it is necessary that reasonable access to all health professionals be guaranteed to ensure consumer health care needs are met. Barriers continue to exist in the health care marketplace preventing non-MD health professionals from competing with physicians and practicing to the fullest extent of their education and training.

An essential first step for creating equitable access to all health professionals is to incorporate into health care legislation, antidiscrimination requirements that prohibit health plans from discriminating on the basis of the category of licensure or certification of the health professional. Our health professional associations succeeded in securing provisions in all major health care reform legislation of the 103rd Congress prohibiting health plans from discriminating against health professionals on the basis of their licensure or certification. This success illustrates the understanding by policymakers of the need to ensure the public's access to appropriate health care services.

By preventing discrimination against qualified health care professionals, consumers will have access to necessary primary and specialty care and will be able to choose among a variety of qualified health professionals. Non-MD health professionals are particularly important to meeting the accessibility needs of consumers in rural and underserved areas. In many situations, these are the only qualified health professionals available to provide care. Therefore, antidiscrimination language should be applied to all types of health plans. Even though limited fee-for-service plans and HMO point-of-service options with higher premiums and additional copays provide some choice, they do not go far enough to guarantee consumer choice.

This antidiscrimination language is not "any willing provider" language. It does not require a health plan to enter into a contract with every individual practitioner, but rather would require the plan to have representatives of a variety of health professions in its network. Antidiscrimination language is intended to give health plans more flexibility than "any willing provider" requirements by allowing health plans the discretion to contract selectively on the basis of an individual health professional's reputation, professional qualifications, etc, while preventing health plans from refusing to contract with entire health professions.

During the last Congress, our associations worked with representatives of the managed care industry to negotiate a compromise approach to preventing arbitrary discrimination against health professionals based solely on their license or certification. This concept of antidiscrimination, supported by non-MD health professional associations and managed care organizations, was included in all major health care reform legislation last year. This language prohibits a state, certified health plan, or certified health plan sponsor from discriminating in the participation of, or denying reimbursement or indemnification to a health care provider who is acting within the scope of the provider's license or certification under applicable State or Federal law, solely on the basis of such license or certification.

An increasing number of states, including California, Michigan and Minnesota, have undertaken or are considering affirmative measures to prevent plans from discriminating against health professionals on the basis of category of licensure. Typically, under these statutes, health plans may specify terms and conditions of affiliation to assure cost efficiency, qualification of providers, appropriate utilization of services, accessibility, convenience to consumers, and consistency with the plan's method of operation. This, of course, is not to say that inclusion of all providers of a certain category is mandated.

We urge the Committees to support this reasonable approach to the issue of discrimination against classes of health professionals. This approach was endorsed not only by several health professional associations, but also by representatives of the managed care industry.

**CAPACITY OF HEALTH PLANS TO SERVE CONSUMERS**

All of the major health care reform proposals of the 103rd Congress recognized the importance of assuring that health plans have the resources and capacity to meet the needs of plan enrollees in a reasonable and adequate manner. Under these proposals, health plans must be certified and demonstrate this ability to provide appropriate care.

Any health care legislation of the 104th Congress should include specific criteria that health plans must meet to demonstrate their capacity to serve the health care needs of enrollees. Our health professional associations and the managed care organizations had agreed to specific criteria that was incorporated into major health care reform legislation last year. This legislative language requires that health plans:

- provide a sufficient number, distribution and variety of health providers to meet the needs of enrollees;
- meet the needs of enrollees with reasonable promptness and in a manner that assures continuity of care;
- appropriately serve the diverse needs of the population including the special resource problems of a designated medically underserved area that is part of the plan's network service area;
- ensure that health services are accessible in the communities and plan service areas in which people live and work; and
- provide information to consumers upon request regarding the plan's certification status, benefits offered, premium cost-sharing and administrative charges under the plan, risk and referral arrangements under the plan, and the number, distribution and variety of health care providers under the plan and the availability of such providers.

We urge the Ways and Means and Commerce Committees to recommend to Congress that every type of health plan be prohibited from discriminating in participation of, or denying reimbursement or indemnification to a health professional who is acting within the scope of the health professional's license under applicable State law solely on the basis of such license or certification. Plans should also be required, at a minimum, to meet certain conditions demonstrating that they have the capacity to serve the enrollees of their plan.

American Academy of Nurse Practitioners
American Association of Marriage and Family Therapy
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American College of Nurse Practitioners
American Occupational Therapy Association
American Optometric Association
American Physical Therapy Association
American Podiatric Medical Association
American Psychological Association
American Speech-Language-Hearing Association
National Association of Nurse Practitioners in Reproductive Health

American Association of PPOs
601 13th Street, N.W. * Suite 370S * Washington, D.C. 20005 (202)347-7600 FAX (202)347-7601

July 28, 1995

The Honorable William M. Thomas
Chairman
Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The American Association of Preferred Provider Organizations (AAPPO) has delivered or submitted testimony to both the Ways & Means and Commerce health subcommittees on the advantages in both cost-containment and beneficiary satisfaction of adding a PPO option to Medicare. We would like to comment further on the subject of qualification and quality standards, the subject of your July 27 joint hearing, and we ask to have this communication included in the record of that hearing.

AAPPO agrees with the prevailing thought that Medicare choices should be expanded, giving Medicare beneficiaries the same options available to those insured in the private market. We are concerned, however, by some proposals now being discussed that would limit those choices to state-licensed, risk-bearing entities.

As discussed in our earlier testimony, most PPOs are not licensed as insurers or HMOs, and do not bear insurance risk. To require them to do so is to bar most PPOs from Medicare participation, thereby barring beneficiaries from an option that would offer both cost savings and provider choice.

AAPPO believes strongly that Medicare must build on the successes of the private sector, including PPOs. PPOs have charted impressive growth and popularity not by trying to replicate HMOs' structure, but by applying utilization and quality management to a fee-for-service base. In essence, PPOs represent *managed fee for service*. Given that 90% of Medicare beneficiaries currently are enrolled in a fee-for-service arrangement, it clearly would be advantageous to encourage this population to move into a more efficient and cost-effective variation. PPOs have the capacity to enroll large numbers of beneficiaries quickly -- but not if they must first undergo the laborious process of obtaining state insurance licensure.

AAPPO by no means suggests that PPOs seek to escape oversight and accountability. Indeed,

we have proposed the development and implementation of federal-level standards to demonstrate PPOs' ability to deliver high-quality care and to protect beneficiary interests. Under the current scenario, we are prepared to work with the Health Care Financing Administration to develop standards appropriate to PPOs' unique structure; however -- as suggested by several witnesses as well as members of the Subcommittees -- it certainly makes sense to suggest that private organizations could fulfill the role of arbiter.

As we have discussed with you, PPOs seek direct contractor status under the Medicare program. As we envision the process, an interested PPO would first demonstrate its qualification by complying with formal standards. It then would contract with Medicare just as it now does with a self-insured employer, i.e., the employer bears the insurance risk, and compensates the PPO via an administrative fee for network access, provider credentialing, quality and utilization management, etc. AAPPO has suggested that negotiated performance targets could form part of this contract, e.g., that average claims would not exceed the level payable under the standard Medicare payment methodology.

AAPPO urges you to allow PPOs to bring their unique strengths to Medicare's assistance. We look forward to working with you to develop standards and contracts that will promote high-quality care, cost savings, and beneficiary satisfaction.

Sincerely,

Gordon B. Wheeler
President and Chief Operating Officer

STATEMENT BY
THE AMERICAN FARM BUREAU FEDERATION
TO THE
SUBCOMMITTEE ON HEALTH
OF THE
HOUSE WAYS AND MEANS COMMITTEE
AND THE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
OF THE
HOUSE COMMITTEE ON COMMERCE
ON
STANDARDS FOR THE MEDICARE PROGRAM

July 27, 1995

The American Farm Bureau Federation, the nation's largest general farm organization, representing over 4.4 million member families in every state and Puerto Rico, appreciates this opportunity to comment on standards for various private health insurance plans seeking to participate in and provide coverage to beneficiaries under the Medicare program.

Medicare is a vital part of the rural health care delivery system. It is not uncommon for rural health care delivery systems to have Medicare recipients account for 60-70 percent of their patient count. Medicare money is critical to the cash flow of rural health care delivery systems. At the same time, Medicare regulations determine whether or not the payments for health care delivered to Medicare recipients is sufficient to pay for the actual cost of care.

The first standard for Medicare in rural areas should be to do no harm. Rural health care delivery systems are fragile because of limited patient loads, long travel for care and the limited availability of health care professionals. The cost of Medicare regulations is an added burden on rural systems that may cause quality of care to suffer or the entire system to shut down.

Two factors are critical in determining the impact that Medicare has on rural health care delivery systems. The first one is that Medicare payments must cover the actual cost of delivering care. Cost shifting between payers of care is rampant throughout the health care delivery industry. That is a well established fact. In rural areas often there are few, if any, segments of the market to shift costs to from Medicare.

As was noted earlier, 60-70 percent of the patient load may be Medicare recipients. Another 10-20 percent may be Medicaid recipients. That leaves 20-30 percent of the patients as private pay or insurance payers. Fewer rural families have health care plans than the population as a whole and the plans are often less generous that those of higher paid urban/ suburban residents. In short, rural areas have few "deep pockets" to pay for the shortfalls in Medicare reimbursements.

In addition, there is the issue of complexity. Each time the Medicare system attempts to "fine tune" the payment system to catch potential excess reimbursements, it makes it harder for rural providers to track the changes and respond. They often lack the administrative support staff and electronic systems to handle the additional details.

The second critical factor for rural health care delivery systems is regulatory flexibility. Rural systems often do not have the support staffs necessary to keep up with the never-ending stream of regulations that must be followed to qualify for Medicare payments. The issue is not the quality of care. The issue is meeting a regulatory definition of what is necessary to provide high quality health care.

The size and location of rural health care delivery systems often prevent them from meeting regulations that are often taken as a matter of course in urban/suburban settings. Patient demand

flows are more variable. Maintaining 24-hours-per-day, 365-days-per-year coverage for certain types of care may be prohibitively expensive when patient loads only require coverage for a third or half that time.

Health care professionals need the flexibility to be cross-trained to do more than one job. Mid-level practitioners need more opportunities to perform activities that may be done by physicians in other settings. The many regulations that focus on equipment requirements rather than on patient outcomes need to be reviewed.

In reality, Medicare is a one-size-fits-all, centralized system, managed from Washington, D.C. It assumes that all recipients are the same, all providers are the same and all portions of the country are the same. Medicare must respond to the needs of rural areas.

The current policy debate on allowing more flexibility under managed care and the use of vouchers for Medicare recipients may be good news for rural providers and recipients. Both policy approaches would move decision making-closer to the providers and recipients of care. If managed care providers are given wide discretion in providing care, they could choose a mix of care-givers consistent with the local delivery systems. The managed care payments per recipient may need to be adjusted for the fact that rural systems do not have as even a spread of risks as urban/suburban delivery systems.

A voucher system would provide some of the same flexibility. In this case the recipients would choose a payment system and a delivery system. They would be more likely to choose one consistent with the currently available rural delivery system. The competition encouraged by the voucher approach would also produce new payment and delivery options.

The current focus on the cost of the Medicare program may be a potent force in making changes in the system. If increased payment and delivery flexibility is the result, it will be good news for taxpayers, recipients and providers in rural areas.

## STATEMENT OF AMERICAN LUNG ASSOCIATION AND AMERICAN THORACIC SOCIETY

These comments are submitted on behalf of the American Lung Association and its medical section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 12,500 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

The ALA/ATS would like to take this opportunity to bring to the attention of the Committee its concerns regarding access to specialty care for the chronic lung disease patient. Under the proposed Medicare reform plan, which focusses principally on enrolling Medicare recipients into managed care plans, the access to specialty care question is paramount for our constituents who suffer from lung disease. In addition to including access to specialty care in Medicare reform, we would also like to see included a provision to end restrictive insurance industry policies that limit Medicare patients' access to the latest pharmaceutical products and medical devices. Furthermore, lifetime monetary caps on prescription drugs and medical devices should be eliminated.

LUNG DISEASE AMONG THE MEDICARE POPULATION

The prevalence of chronic lung disease varies with age, but for most categories chronic lung disease hits hardest in individuals 65 years of age and older. For instance, the prevalence of chronic bronchitis is the highest in those over 65, where 61.7 persons per 1,000 are affected. The prevalence of emphysema increases steeply with age, affecting 15.6 people per 1,000 in the 45-to 64-year-old group and nearly doubling to 29.8 per 1,000 after age 65. In addition, those over age 65 experience the second highest prevalence of asthma -- 48.2 per 1,000.

With these statistics in mind, it is only natural that the ALA/ATS be concerned with how Medicare recipients with chronic lung disease are treated under Medicare reform. If current proposals prevail, there will be an increasing number of Medicare recipients enrolled in managed care. The ALA/ATS wants to make sure that those with chronic lung disease will receive the same quality care and access to specialty care they receive under the present Medicare system.

THE NEED FOR ACCESS TO SPECIALTY CARE

In order to maintain optimal functioning in the face of a disabling condition such as chronic lung disease, patients require a wide range of health-related services. Medical treatment is, of course, primary. In terms of physician care, the patient's family physician usually makes a tentative diagnosis of chronic lung disease. In most instances, a consultation with a pulmonary specialist is suggested. In some cases, because of the extent of the patient's disease, referral to a pulmonary specialist is necessary.

Specialists serve a dual role in clinical practice: as a primary physician for a person with chronic disease and as a consultant for acute illness where the patient has been referred to the specialist. A gatekeeper system that too strictly requires permission or referral for every visit to a specialist would be a large detractor to access for people with chronic lung problems. Appropriate management of moderate to severe asthma by a specialist, for example, is more likely to result in fewer costly hospitalizations than care of those same cases by a general internist or family practioner who does not have the extensive training to work with asthma. Further, pulmonary physicians are generally able to assume full care for the patient whose primary problem is lung related and more often do so at the patient's request.

Just as there is a need to include specialty care access in Medicare reform, there also remains the need to train specialists to perform those services. The ALA/ATS is concerned that every effort be made to continue funding of Graduate Medical Education (GME) through a Medicare set-aside. Although the trend of the medical profession is to produce more primary care physicians, the fact remains that with a growing elderly population, the need for specialized services, such as critical care/pulmonology, will continue to grow well into the next century.

The American Lung Association and the American Thoracic Society are dedicated to ensuring that

lung disease patients on Medicare have access to the appropriate specialty care. Unless there is specific language in the Medicare reform bill mandating an out-of-service option for managed health care plans, access to providers who are specialists for individuals with chronic diseases (e.g. a specialist acting in the primary care provider role) may be denied, or severely restricted in the interest of cost savings. Financial disincentives for specialty referral also must be eliminated. Referrals always must be based on the best interest of the patient, not the financial interests of the health plan.

MEDICARE RECIPIENT ACCESS TO LATEST PRESCRIPTION DRUGS AND DEVICES

A variety of oral, parenteral and aerosolized medications are required to treat chronic pulmonary disease. In addition, some patients require oxygen and durable medical equipment, such as nebulizers, humidifiers, suctioning equipment and mechanical ventilators. New drugs and devices that can better control and add improve the quality of life for lung disease patients are being made available daily. Unfortunately, Medicare recipients cannot receive the latest/experimental drugs or devices because of restrictive Medicare payment policies. As a result, these patients, who are often in most need of advanced drugs and devices, are being denied access to a series of new products and therapies.

Compounding this already stifling situation are lifetime caps on prescription drugs and medical devices. The cost of treating chronic diseases is very expensive. Lifetime monetary caps on these therapies cruelly postpone the inevitable for those with chronic conditions. For patients who have exceeded their lifetime cap, finding other cost-effective health insurance to help pay for their ongoing medical costs is a nightmare, if not impossible.

Studies have been conducted indicating that the eradication of lifetime caps would result in minimal increases in insurance premiums. Insurance companies can effectively spread their risk of having patients with catastrophic illnesses through reinsurance. From an actuarial view, there is a trivial increase in premium costs from raising the lifetime cap from half a million or a million dollars to six million dollars or eliminating it altogether -- the difference for the patient who has a chronic and costly disease, however, is tremendous.

CONCLUSION

With the ever increasing number of Medicare recipients enrolling in managed care plans and considering proposed legislative plans to encourage this trend, Congress should make sure that the issues of access to specialty care, the ending of restrictive Medicare drug and medical device policies, and the elimination of lifetime caps on prescription drugs and medical devices are thoroughly reviewed.

Continued access to specialty care, prescription drugs, medical devices and the elimination of lifetime monetary caps are of extreme importance to those with chronic diseases, especially chronic lung disease. It is the hope of the American Lung Association and the American Thoracic Society that the committee will seriously and carefully consider these options when formalizing its final plan for Medicare reform.

STATEMENT OF AMERICAN REHABILITATION ASSOCIATION

BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

AND

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
COMMITTEE ON COMMERCE

FOR THE RECORD OF THE HEARING ON STANDARDS FOR HEALTH PLANS
PROVIDING COVERAGE IN THE MEDICARE PROGRAM

July 27, 1995

This testimony is being submitted on behalf of the American Rehabilitation Association for inclusion in the record of your subcommittee's hearing on standards for health plans providing coverage in the Medicare program.

The American Rehabilitation Association (formerly the National Association of Rehabilitation Facilities) is the largest not-for-profit organization serving vocational, residential and medical providers in the United States. The established leader in the field of rehabilitation for more than a quarter century, American Rehab serves its more than 800 member facilities by effecting changes in public policy, developing educational and training programs, and promoting research. In addition, it provides networking and communications opportunities, all of which help to ensure quality care and access to services to more than four million persons with disabilities.

This testimony will provide background on rehabilitation, discuss the impact that managed care has had on rehabilitation, and outline standards for plans providing care to Medicare beneficiaries.

**BACKGROUND ON REHABILITATION**

Medical rehabilitation addresses itself to a single end--the elimination or mitigation of disability. Rehabilitation restores a person's ability to live, work and enjoy life after an illness, trauma, stroke or similar event has impaired his or her physical or mental abilities. Most patients enter rehabilitation after an acute hospital stay. In 1994 about 400,000 people per year received such services as inpatients in rehabilitation hospitals or rehabilitation units of general hospitals. Many more receive such services as outpatients. There are now about 200 rehabilitation hospitals and 800 rehabilitation units in general hospitals.

Many of the conditions requiring rehabilitation are associated with advancing age, particularly strokes, arthritis and orthopedic conditions. Accordingly, a relatively high percentage of the persons who need rehabilitation are covered by Medicare. In 1994 about 71% of discharges from rehabilitation hospitals and units and 66% of total days of care were covered by the Medicare program. These figures do not include Medicare beneficiaries who have chosen to enroll in managed care plans. Thus, rehabilitation facilities are perhaps more affected by Medicare policy than any other element of health care.

Rehabilitation involves specialized physicians, rehabilitation nurses, physical and occupational therapists, speech language pathologists, respiratory therapists, social workers, psychologists, and other therapists who work as a team with patients to restore their functional ability and help them be independent. This interdisciplinary team concept is central to rehabilitation and the sum of these efforts is greater than the parts. The team establishes an individual rehabilitation plan which sets forth that person's goals in rehabilitation. For example, a person has had a stroke which impairs the ability to walk, see, swallow and creates weakness on the left side. The goals include walking again independently, swallowing without aid, seeing well enough to read, strengthening the left side so the arm and leg can be used, and being able to dress independently again. Over 80% of the 4 million people receiving rehabilitation services return to their homes,

work, schools, or an active retirement. Common conditions usually requiring rehabilitation include: heart attack, stroke, arthritis, cancer, neurological disorders, joint fractures and replacements, amputation, head injury, spinal cord injury, chronic pain, pulmonary disorders, burns, multiple trauma and congenital or developmental disorders.

Rehabilitation is delivered in freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, skilled nursing facilities and in people's homes. Determining which setting is appropriate is a function of medical judgement. These settings provide a full continuum of rehabilitation care.

The rehabilitation field is responding to the changes in the health care field. It is becoming more cost effective through the use of critical pathways, decision rules and constant examination of the use of resources and outcomes. All of these practices help make decisions about the appropriate use of resources and help cut costs.

**EFFECTIVENESS OF REHABILITATION**

If rehabilitation services are delivered, they are most effective if delivered early after trauma or illness. For example, rehabilitation is one of the evaluations done right in the trauma center. If an appropriate referral is not made the person remains dependent, the family suffers and society, the individual and the family pay more than just financially. In a study of the cost benefits of stroke, the investigators found that for each stroke patient who, through rehabilitation, was able to live at home, the expense of living at home versus in a nursing home setting saved $13,248 per year in 1981 dollars, or $21,599.54 in 1994 dollars per year. Given that the average stroke patient lives over 5 years this is a savings of $107,997.70 in 1994 dollars.

An article in the 1994 October/November/December issue of TQM magazine, "Judging the Cost-Effectiveness of Rehabilitation", discussed the cost effectiveness of rehabilitation. Pulmonary rehabilitation improves patient function and reduces the use of medical services. Early rehabilitation in a rehabilitation unit for stroke patients is more effective than for patients treated on general medical wards. Twice as many of the patients who did not receive rehabilitation went to nursing homes and the mean time in an institution in the first year, including nursing homes was 75 days for the rehabilitation patients and 123 days for the patients who did not get the rehab program.

For traumatic brain injury (TBI) early initiation of rehabilitation can save costs. A recent study compared patients from one hospital with an aggressive early rehabilitation program for TBI with those from 11 other hospitals without organized programs. Patients from the formal program experienced one third the time in a coma. Also the rehabilitation length of stay averaged 54 days vs. 106 days for those coming from routine care. Ninety-four percent (94%) were discharged home in the early intervention program compared to 57% of the others. Again, there is an enormous amount of money saved simply by calculating the cost of days **not** spent in the hospital.

**MEDICARE, REHABILITATION AND HMOs**

As noted previously, the Medicare program impacts the medical rehabilitation industry significantly in accounting for 66% of inpatient days. It has been suggested that one means of reducing the rate of increase in overall Medicare expenditures is to encourage more Medicare patients to enroll in plans other than the traditional fee for service plan. Options being considered include managed care, medical savings accounts and employer plans. We are most familiar with managed care and raise some issues related to medical savings accounts as well.

At present only about 9% of Medicare beneficiaries have chosen to move from fee for service Medicare to HMOs and other managed care plans. This relatively low rate of enrollment obscures the fact that managed care enrollment is much higher in certain parts of the country, particularly on the west coast. In California, for example over 20% of Medicare patients are enrolled in managed care plans.

In concept there are two reasons why managed care plans can provide care at lower cost than traditional forms of insurance and health care delivery. First, it is assumed that by hiring or contracting with providers of services to significant patient populations, HMOs and other managed care plans can achieve economies of scale (or drive hard bargains). Second, through "management" of care through gatekeeper physicians and other controlling mechanisms, they can avoid delivery of ineffective or superfluous services and, thereby, avoid the associated costs.

In fact, there is a third factor, denial of services. Enrollees may find that certain services are not provided, either because they are deemed to be unnecessary or because of contract limitations, the effects of which are not appreciated until it is too late. This observation is not to suggest that HMOs and other managed care plans seek to deceive enrollees, but rather that certain specialty services needed by a relatively small number of people do not receive adequate consideration by either the plan or the enrollee until the service is needed.

About four million people annually receive some type of therapy service. Of these about 400,000 are admitted to a rehabilitation hospital or a rehabilitation unit in a general hospital. Thus, the chance that any given individual will need rehabilitation services is slight.
This means that it is unlikely that a person shopping for HMO coverage will anticipate the need for and coverage of rehabilitation services.

Rehabilitation services are intense and of longer duration than acute care. By their very nature managed care plans seek to avoid or minimize the cost of such services. Our association recently surveyed member facilities. Sixty nine percent (69%) of the rehabilitation hospitals and units to which HMOs referred Medicare patients reported that the HMO limits the numbers of days of therapy, with an average limit of 51 days. We find this information about Medicare beneficiaries particularly disconcerting because it is our understanding that the Medicare package of benefits is to be available to Medicare rehabilitation patients. Under Medicare there are no day limits on therapies or programs. Medical necessity is determined by the Medicare inpatient rehabilitation hospital guidelines.

The Medicare Advocacy Project, Los Angeles, California, in its January 1993 report, "Medicare Risk Contract HMOs in California: A Study of Marketing, Quality and Due Process Rights" noted the noted the following problems:

* Failure to refer for needed specialty care. The decision may not be made by the gatekeeper physician but by the medical group manager, utilization review coordinator or medical director. They also cited the physician financial incentive issues mentioned above.

* Not having enough contracting specialty physicians available or when the financial incentives delay referrals to specialty physicians.

* Failure to refer for rehabilitation. The frequency with which HMOs deny access to home health care and inpatient rehabilitation services... "raises questions about the financial incentives under which HMOs and their subcontracting provider groups operate." The report questions the HMOs determinations that cases that appear to meet the Medicare coverage guidelines were denied the care as not medically necessary.

The quality of care given to many HMO Medicare enrollees is also a big concern. This is a difficult issue to quantify. As noted, we have heard about problems with people either not being referred at all for rehabilitation or being referred but with a limit on the number of days. Quality goes to the setting to which the patient is referred for services and the duration, frequency and type of treatment they receive. Our members have told us about enrollees, both Medicare and non-Medicare, being sent to what we characterize as a custodial institutional setting that provides either no or periodic skilled nursing and rehabilitation therapies as required under OBRA '90, but not a comprehensive rehabilitation program. Our members do not believe many of these patients obtain their maximum outcomes and the rates of return to home, work, school and an active retirement are not as high as possible. This is a tragic personal, professional, familial, social and financial loss and burden.

The Medicare Advocacy Project Report cited above noted several cases where the HMOs approved less care than needed. The report states the "survey also points to possible systemic bias by some HMOs against referrals for in-patient rehabilitation services. All five of the southern California in-patient rehabilitation hospitals responding to MAP's survey felt that some Medicare HMOs denied medically necessary rehabilitation services to a greater extent than occurred in FFS [fee for service]. " The report further states "some HMOs appear to use arbitrary standards to deny or discontinue rehabilitation care." These standards include the patient's age even when a patient was improving.

The Mathematica study released in December, 1993 also raised concerns about quality of care. Mathematica looked at rates of death, hospital readmission and post admission complications as gross outcomes" measures but did not make any adverse findings. However it did state," ..,a few differences do indicate that HMOs may be providing less adequate care in some situations. ...HMO stroke patients received significantly less physical therapy while in the hospital and had greater motor and speech deficits at discharge, yet were not more likely to have a post discharge speech or physical therapy plan. This pattern suggests that HMOs may economize on rehabilitation care...Although there is no evidence that these differences in care led to poorer patient outcomes, they cause some concern because of their potential adverse effect on outcomes."

The study noted that HMOs discharge a higher proportion of stroke patients to nursing homes and a lower proportion to rehabilitation hospitals. While it did not have follow up data, this practice raised concerns about whether this pattern was leading to poorer care.

Managed care should not be used to deny rehabilitation and other specialty services from which patients can profit. Denial of such services in the name of economy is an illusion. The managed care plan or society as a whole will end up paying higher acute medical and/or social costs.

## RECOMMENDATIONS ON PLAN STANDARDS

As this committee looks for ways to bring Medicare into the next century and ensure its financial viability, it will look to assure that any health plan serving Medicare beneficiaries meet certain standards. The movement to restructure Medicare and focus on multiple options, including managed care, must assure that any kind of plan meets certain criteria regarding benefits, marketing practices, solvency, reporting, quality of care delivered and quality of outcomes, plus grievances and sanctions, at a minimum. To that end we suggest the following be included. Furthermore, we recommend that any national accrediting body's standards relied upon must also cover these points.

### *1. Plan Information*

Plans should provide uniform written descriptions of their benefits, services and procedures that clearly and fully disclose coverage of benefits, exclusions, limitations on coverage, and out-of-pocket costs, including copayments, deductibles, coinsurance, and established aggregate maximums on out-of-pocket costs.

### *2. Evaluation*

Patients who have impaired functional abilities should receive a rehabilitation evaluation by a specialist in physical medicine and rehabilitation as quickly as possible once they experience an illness or injury. Studies have shown that the earlier a patient is evaluated and receives rehabilitation services, the more successful the outcome. If an enrollee is a candidate for rehabilitation he or she should have access to, and be referred for, those services.

This evaluation would be for individuals a) with one of the conditions usually requiring rehabilitation services, b) with a congenital disability, and/or c) with a specific functional level based on a functional assessment and occur within 72 hours upon seeing a primary

care provider or other gatekeeper. The conditions in question include, but are not limited to, stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, all forms of arthritis, neurological disorders, burns, cancer, cardiac and pulmonary diseases and pain.

*3. Coverage*

Any plan offered to Medicare beneficiaries should offer those benefits for rehabilitation services from rehabilitation providers which are currently covered in the Medicare program. Additionally, there are coverage guidelines for inpatient rehabilitation hospitals and unit services and outpatient services. They are based on the patient's need and progress, not an arbitrary limit. The current Medicare inpatient and outpatient guidelines should be used by plans while options are examined.

*4. Incentives*

Financial and other incentives for physicians to refer to physician and nonphysician specialists should be based on the needs of the patient and the patients' outcomes. All financial and other incentives should be disclosed to patients, employers and other purchasers of the plan's services.

*5. Quality*

Managed care plans should be accountable for the quality of care provided. They should ensure adequate access to services for all their enrollees. Outcomes, both medical and functional, should be reported by insurers to employers, government payers and enrollees. Quality criteria by which to determine plan approval of rehabilitation services to Medicare beneficiaries should include (a) patient outcomes, including but not limited to, death, pressure sores, discharge status, and change in functional motor and cognitive function, and others; and (b) readmission to the hospital. Additionally, with respect to access, plan standards must address maximum waiting periods for appointments, for referrals to specialists as wee as initial and follow up appointments to nonspecialists and maximum travel distances. All this information should be available to the public.

*6. Specialists as Gatekeepers*

Enrollees who require ongoing, specialized health services should be able to choose a specialist as a gatekeeper in order to effectively manage the services appropriate to their conditions. Relevant specialists should also be directly available to enrollees without gatekeeper approval where continued specialized care is medically indicated. Persons requiring rehabilitation services and persons with disabilities in particular should be able to select a primary care provider or gatekeeper who is a physiatrist, an otherwise qualified rehabilitation physician or a specialist in the medical management of their particular condition.

*7. Consumer and Provider Due Process*

Plans should set forth procedures to be followed in the resolution of disputes with enrollees about required services and the adequacy of those provided by the plan. Grievance mechanisms should be timely and fair.

Grievance and appeals procedures should:

a) be available to both enrollees and providers, including timely review of a service denial;

b) be clearly communicated to all parties;

c) require independent second opinions to be obtained promptly when covered benefits

are denied for any reason;

d) require an expedited appeals process leading to a decision within 72 hours of the initial complaint.

*8. Arrangements with Providers*

Plans should enter into agreements and other arrangements to ensure an appropriate mix, number and distribution of qualified health professionals to adequately provide for the plan's benefit package.

*9. Utilization Management Protocols*

Utilization review should be performed by qualified personnel knowledgeable in the field in which a coverage decision is being made. Qualified health professionals, including rehabilitation providers and other specialists, should be involved in the development and implementation of utilization review procedures and practice guidelines.

*10. Ability to Opt Out*

Ultimately, it may be impossible to adequately protect the interests of severely disabled persons requiring intensive rehabilitation services through the types of procedural requirements outlined in this testimony. We recommend that if such an enrollee is dissatisfied with the type or quality of rehabilitation service provided, then he or she have the option to return to Medicare fee for service coverage promptly, as enrollees can do now by disenrolling from the managed care plan within a month. We recommend that this process be made simpler, be clarified and be included in all plan literature.

*11. HCFA's Responsibilities*

HCFA should direct HMOs now and plans in the future that they cannot use arbitrary rules of thumb to deny rehabilitation care to Medicare beneficiaries, e.g. age or deny any Medicare benefits to beneficiaries. If an enrollee is a candidate for rehabilitation and meets the existing Medicare inpatient rehabilitation hospital or outpatient guidelines, he or she should be referred for those services.

HCFA should increase its review of Medicare risk contractors' practices in referring patients who require rehabilitation to less intense levels of services which may result in decreased positive outcomes.

*12. Consistency*

Plans should be consistent in the information required, i.e., data elements and methods of analysis, evaluation criteria, assurance of non-discrimination among classes of providers, uniform quality and utilization standards, outcomes assessment, assurance of access, fair and adequate reimbursement, consistency of record-keeping requirements.

*13. Point-of-Service Option*

HMO enrollees should have the right to obtain care from out-of-network providers, assuming they opt to pay the any extra costs. It retains the ability of closed-panel HMOs to contain costs, but also allows enrollees the flexibility to opt out of the provider network if they pay a little more for this option.

MEDICAL SAVINGS ACCOUNTS

We have examined some descriptions of medical savings accounts. Several issues arise that are of concern for persons in need of rehabilitation services and providers of those services. First the catastrophic health plans should not be allowed to impose preexisting condition limitations nor to refuse to cover persons based on health status, especially persons with disabilities. Second such plans must be required to provide comprehensive coverage for persons with serious illnesses or injuries requiring rehabilitation services. Third, there should be no lifetime or per condition limits for persons experiencing a catastrophic injury or illness which requires rehabilitation. Fourth, such plans should be required to include rehabilitation services in their benefits package since the majority of conditions considered catastrophic, e.g. stroke, head injury, brain injury, etc., require rehabilitation services in order to restore the person to their prior functional level.

We would be pleased to discuss these critical issues with you Mr. Chairman.

Respectfully submitted,

Carolyn C. Zollar
Vice President for Public Policy and General Counsel

**STATEMENT OF JAMES W. PATTON**
**ON BEHALF OF COMPREHENSIVE HEALTH SERVICES OF DETROIT**

We commend Chairman Thomas and Chairman Bilirakis for taking on the task of reviewing standards for health plans providing coverage in the Medicare program. Congress has the opportunity to replace multilayered standards with uniform standards for comparable health care systems.

Issue - 50/50 Rule

Health Maintenance Organizations which serve the Medicaid population are often precluded from serving the Medicare population because of the Medicare requirement that at least 50 percent of their members must be covered other than through Medicare or Medicaid (the 50/50 rule). The intended purpose of this rule is to ensure quality in Medicare HMOs through limiting member composition to no greater than 50% Medicare and Medicaid. The goal of this Congress to encourage more Medicare beneficiaries to receive their health care in managed care settings is being impeded by the 50/50 rule. To achieve its goal, Congress should at a minimum require the Secretary of Health and Human Services to automatically waive the 50/50 rule for plans which meet certain quality and financial standards.

Background on CHS

Comprehensive Health Services (CHS) of Detroit, known as The Wellness Plan, is a 501(c)(3) federally qualified health maintenance organization ("HMO") operating since 1972 and serving the Detroit metropolitan area. Currently, CHS has over 140,000 enrollees, approximately 90 percent of whom are enrolled through the state of Michigan Medicaid program. CHS currently has roughly 2,000 Medicare enrollees with marketing plans to reach 15,000 enrollees in the next few years.

CHS has over 200 commercial accounts with medium and small businesses, enrolls nearly 10 percent of the federal employee health benefit plan participants in Detroit, and has accounts with major companies. However, CHS has a disproportionate percentage of Medicaid members from sectors of the city of Detroit with the greatest preponderance of minority and low income populations. In practice, it is not realistic for an inner-city HMO like CHS that serves a significant number of Medicaid beneficiaries to meet the 50/50 rule.

CHS is a well established HMO that has been recognized as a model quality Medicaid managed care program by such national leaders as Dr. Otis Bowen, former Secretary of the Department of Health and Human Services. Based on its stellar performance, CHS is as qualified as any other HMO in serving Medicare patients. Indeed, despite the fact that it often serves the sickest and most vulnerable population in the city of Detroit, including many dual eligible persons (with Medicare and Medicaid coverage), its costs to the Medicare program are far below the average adjusted per capita cost rates paid to Medicare risk contractors.

CHS has had a Health Care Prepayment Plan (HCPP) contract with Medicare since 1993. While CHS would have preferred to have a risk contract, it was and remains ineligible to participate in these contracts because of the 50/50 rule.

Under the Medicare technical corrections legislation enacted last year, HCPPs must comply with State Medigap requirements as of January 1, 1996. However, Medigap rules prohibit activities which are fundamental to HMO operations such as imposition of reasonable copayments and coverage of preventative care. Further, CHS cannot comply with Medigap because it is not licensed as an insurance company. Because compliance with Medigap is impossible, CHS would like to convert its HCPP contract to a Medicare risk contract, but again, this is impossible because of the 50/50 rule.

**Standards for Automatic Waiver of 50/50 Rule for Medicaid Plans**

The Secretary of HHS should be required to automatically grant waivers for plans that cannot meet the 50/50 rule due to significant Medicaid enrollment if they meet the following criteria:

- Operational Medicaid risk contract for at least three consecutive years;
- Enrollment of at least 25,000 Medicaid recipients;
- Financial Soundness as documented by at least one of the following:
  - a net surplus of income over expenses over the past three years
  - net worth equal or exceeding two months of medical expenses
  - medical loss ratio of not less than 75% over the past two years
- Quality plan as documented by meeting at least one of the following:
  - federal qualification
  - satisfactory disenrollment for cause rates, beneficiary appeal rates, and track record of state/federal compliance actions or other measures of consumer satisfaction (e.g., independent customer satisfaction surveys documenting favorable ratings from a high percentage of respondents)
  - accreditation by a private accreditation body.

The Secretary should also have authority to grant waivers on a case by case basis for other Medicaid plans not meeting the above standards.

**Further Specific Concern of CHS**

At the end of the 103rd Congress a law was enacted known as the Social Security and Technical Corrections Act of 1994, H.R. 5252 (dated October 7, 1994). Section 171(f) would subject an HCPP contractor to Medigap laws and regulations as of January 1, 1996. Because these provisions are inherently contrary to the operations of HCPPs, Section 171(f) would make it impossible for an HCPP contractor to offer a "gap policy" to any of its individually enrolled Medicare members. This is critical because, without a gap policy Medicare beneficiaries would have no reason to enroll or remain enrolled in an HCPP contractor. Rather, HCPPs would have to limit offers of gap policies to persons enrolled in a group contract (e.g. Medicaid dually enrolled Medicare beneficiaries, retirees of union trust plans and employer group retiree plans), who do not fall under the scope of Section 171(f).

Historically, HCPP contractors generally, and all federally qualified HMOs, were exempt from the federal Medigap laws. HCFA apparently interprets Section 171(f) as restricting an HCPP contractor from offering a gap policy unless it is in conformance with requirements for a Medicare Supplement Policy ("Medigap policy"). Because Medigap policies are indemnity policies and because most federally qualified HMOs and most other state licensed HMOs are not licensed insurers, it is impossible for them to offer such policies solely through an HCPP.

Moreover, under federal law, a Medigap policy must reimburse benefits regardless of which provider or physician offers the care. Congress has provided an exception to the Medigap requirements enabling insurers and Blue Cross Blue Shield plans to offer Medicare Select, a Medicare PPO product. Even though Medicare Select allows for differences in reimbursement between in-network and out-of-network providers, it does not address most of the conflicts for HCPPs attempting to comply with Section 171(f). Specifically, by requiring an HCPP contractor to conform to

Medicare Select, Section 171(f) would preclude an HCPP from offering its own unique version of covered benefits and require instead that the HCPP gap policy conform to 1 of 10 standard Medigap policies. None of these policies permit an HCPP contractor to use modest copayments (i.e., $5 to $10 for office visits and $25 to $50 for use of a hospital emergency room) to help manage usage of services by Medicare enrolled members of the HCPP. Nor does Medicare Select allow an HCPP to offer more comprehensive or more generous benefits, including extensive preventative care services that are not covered by Medicare or by Medigap policies.

Moreover, even for provisions that do not directly conflict with the obligations of an HCPP contractor, some requirements of Medicare Select, if implemented, could increase dramatically the administrative costs of operating an HCPP program. For example, even though the HCPP is paid its costs in lieu of the billed fees from a Medicare carrier, Section 171(f) would require an HCPP to submit bills to a Medicare carrier. Accordingly, the framework created by Section 171(f) is contrary to the framework of operating as an HCPP.

It is ironic that Congress, by adopting Section 171(f), could undermine the HCPP program when it has been a source of long term stable participation of HMOs with Medicare. Unlike the HMO risk program, HCPPs have not been criticized for having financial incentives to favorably select only healthy patients. Yet, HCPPs have served as an important feeder program that enables HMOs to shift to risk contracts once they gain experience in managing Medicare population. Few HCPPs have dropped out of the Medicare program and since the inception of the risk contract program 14 of the largest and most successful risk contractors were previously HCPPs. By contrast, in the first eight years of the risk contract program approximately 300 out of 400 contracts (or 75 percent) were terminated or non-renewed. **Accordingly, if Congress does not provide for a waiver of the 50/50 rule for Medicaid plans, it will be impossible for HCPP contractors such as CHS to expand coverage to additional Medicare beneficiaries. In the absence of a 50/50 waiver, CHS finds it necessary to seek a solution to its specific problem.**

Alternatives (all of which are budget neutral) might include:

- Specifically waive the applicability of the 50/50 rule to CHS;
- Postpone the effective date of the requirement that HCPP contractors comply with Medigap rules for those HMOs that cannot meet the 50/50 rule (and therefore cannot otherwise serve the Medicare population on a managed care basis) until such plans can qualify for a risk contract;
- Delete the requirement that HCPP contractors comply with Medigap rules and instead impose quality standards on HCPP contractors.

At a time when the Congress is looking toward managed care as one option for reducing the rate of growth in the Medicare program, destroying the ability of CHS to serve the Medicare population on a managed care basis would be truly counterproductive.

* * *

If you have any questions or wish to obtain additional information regarding this statement, please call our Washington Counsel, Wendy Krasner at (202) 778-8064 or Kathleen Black at (202) 778-8342 of the firm of McDermott, Will & Emery in Washington, D.C.

## STATEMENT OF D.C. CHARTERED HEALTH PLAN, INC.

**Issue**

Health Maintenance Organizations which serve the Medicaid population are often prohibited from serving the Medicare population because of the Medicare requirement that at least 50 percent of their members must have insurance coverage other than through Medicare or Medicaid (the 50/50 rule). The intended purpose of this rule is to ensure quality in Medicare HMOs through limiting member composition to no greater than 50% Medicare and Medicaid. The goal of this Congress to encourage more Medicare beneficiaries to receive their health care in managed care settings is being impeded by the 50/50 rule. To achieve this goal, Congress should, at a minimum, require the Secretary of Health and Human Services to automatically waive the 50/50 rule for established plans which primarily serve Medicaid recipients and meet certain quality and financial standards.

**Background on Chartered Health Plan**

Chartered Health Plan ("Chartered") is a prepaid health care plan under contract with the District of Columbia Government (the District) to provide health care services since fiscal year 1988. It began this contract when all other HMOs in the District were unwilling to serve Medicaid recipients.

Chartered has a proven track record of dealing effectively with the hard core Medicaid population in the District. Indeed, Chartered is currently establishing state of the art primary health care centers in the two most under-served, crime ridden, and economically challenged areas of the city. Chartered is committed to serving the Medicaid population with adequate access to high quality care. During the course of serving the Medicaid population, it has found that many of its services are needed and sought by Medicare beneficiaries who reside in the inner city. However, Chartered is unable to enroll these persons in its plan because of the 50/50 rule.

In addition to supporting automatic waivers of the 50/50 rule, Chartered is seeking similar requirements for the Secretary with regard to the Medicaid 75/25 waiver.

**Background on Medicare/Medicaid Dual Eligibles**

Even though the District of Columbia Government has embraced managed care as a cost saving alternative to traditional Medicaid coverage, it is currently limited to Medicaid beneficiaries entitled due to coverage under Aid to Families with Dependant Children ("AFDC"). The sickest and most expensive Medicaid patients are those who are also entitled to coverage under the federal Supplemental Security Income ("SSI") program -- "dual eligibles". Typically, insurance companies and HMOs have avoided underwriting this population.

Chartered is now seeking to work with the District to develop a program for joint coverage of SSI beneficiaries with the Medicaid program. To expand the scope of its services to SSI beneficiaries, Chartered would need both a waiver of the 75/25 Medicaid composition rule and a waiver of the 50/50 Medicare enrollment composition rule.

In order to serve this segment of the population, Chartered is willing to become a federally qualified HMO or federally approved Competitive Medical Plan ("CMP"). Chartered also plans to become approved by NCQA, the private HMO accreditation organization and has recently been licensed as an HMO in the state of Virginia.

Dual eligibles are cumbersome to handle because they require two separate contracts, one with the Medicaid program and a second with the Medicare program. A critical factor in

explaining why this population remains untargeted by managed care programs is that these beneficiaries have chronic and acute medical problems that pose substantial costs to both the Medicare and Medicaid programs. Accordingly, these beneficiaries are often unattractive to HMOs because they are difficult to manage and have adverse medical histories. Medicaid agencies are beginning to encourage these populations to join Medicare risk or cost contractors because they are required by federal law to cover the gaps in Medicare and because the Medicare program provides primary coverage and the Medicaid program provides secondary coverage. Yet, few HMOs are ready to serve these populations.

**Standards for Automatic Waiver of 50/50 for Medicaid Plans**

The Secretary of Health and Human Services should be required to automatically waive the 50/50 rule for a plan with significant Medicaid enrollment if the plan meets the following criteria:

- Operational Medicaid risk contract for at least three consecutive years;
- Enrollment of at least 25,000 Medicaid recipients;
- Financial Soundness as documented by at least one of the following:
  - a net surplus of income over expenses over the past three years
  - net worth equal or exceeding two months of medical expenses
  - medical loss ratio of not less than 75% over the past two years
- Quality plan as documented by meeting at least one of the following:
  - federal qualification
  - satisfactory disenrollment for cause rates, beneficiary appeal rates, and track record of state/federal compliance actions or other measures of consumer satisfaction (e.g., independent customer satisfaction surveys documenting favorable ratings from a high percentage of respondents)
  - accreditation by a private accreditation body.

Further, the Secretary would also have authority to grant waivers on a case by case basis for other Medicaid plans not meeting above standards.

Precedent for a waiver of the Medicare enrollment composition rule already exists for individual health plans that were targeted to the Medicaid population. We believe it is now time for other urban based HMOs with significant experience in serving Medicaid patients to be allowed to operate as Medicare contractors.

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If you have any questions or wish to obtain additional information regarding this statement, please call our General Counsel, Jerrold Hercenberg at 703 758-3604 or call Wendy Krasner at 202 778-8064 or Kathleen Black at 202-778-8342 of the firm of McDermott, Will & Emery in Washington, D.C.

## STATEMENT OF JOINT COMMITTEE FOR PATIENTS IN PAIN

### MEDICARE REFORM AND THE FEDERAL BUDGET

**The American Pain Society, the American Academy of Pain Medicine, and the American Association for the Study of Headache** have formed the **Joint Committee for Patients in Pain** to advocate responsible public policy and private sector action for the benefit of millions of Americans who suffer from intractable pain.

While pain affects patients of all ages, it is closely associated with many illnesses that afflict the elderly, including cancer, diabetes, and arthritis. Chronic pain is also closely associated with disability; in fact, intractable pain is frequently the cause of disability. Thus, access to appropriate treatment for pain is a core issue for Medicare beneficiaries, particularly those with serious illness and disability who by necessity are disproportionately large consumers of Medicare financed health care services.

The 104th Congress is considering changes to the Medicare program which are more fundamental than any considered since the original enactment of Medicare in 1965. Most proposed changes would move more Medicare patients towards private sector health plans, or bring managed care practices from the private sector more fully into the public plan. As Congress considers these dramatic changes, caution must be taken to ensure that Medicare patients in pain do not lose access to appropriate care.

As with certain other illnesses, complex pain cases are not effectively treated in tightly controlled systems emphasizing primary care services. Pain and its underlying causes are frequently misdiagnosed - or undiagnosed. Patients are frequently mistreated, under treated, or untreated. "Gatekeepers" impede rather than facilitate appropriate early intervention. These cases stand out. They are not "routine," but they are widespread, and often become very high cost. They require special consideration in a reformed Medicare program.

Intractable pain can be intolerable to the patient. It impacts so dramatically on the quality of life and the ability to function as to prompt desperate searches for relief in and out of a patient's primary health network, and in and out of proven treatment modalities. At some point, it even becomes unbearable. Though often lost in the rancorous debate over assisted suicide, it is a fact that most of Dr. Jack Kevorkian's patients have been sufferers of intractable pain.

Medicare reforms must deal fairly and effectively with the special needs of patients in pain. The Joint Committee for Patients in Pain urges Congress to consider the following protections for patients afflicted with intractable pain:

## JOINT COMMITTEE FOR PATIENTS IN PAIN

I. MEDICARE BENEFICIARIES SHOULD HAVE A FEE-FOR-SERVICE AND A POINT OF SERVICE OPTION AVAILABLE AT ALL TIMES OF MEDICARE ENROLLMENT. THESE OPTIONS SHOULD BE REAL - NOT SUBJECT TO INORDINATELY HIGH PREMIUM OR CO-PAY DIFFERENTIALS, OR UNDUE RESTRICTIONS ON THE ABILITY TO SWITCH PLANS.

II. QUALIFIED MEDICARE PLANS THAT UTILIZE RESTRICTED PROVIDER NETWORKS MUST BE REQUIRED TO DEMONSTRATE CAPACITY TO EFFECTIVELY TREAT INTRACTABLE PAIN WITHIN THE NETWORK, OR THROUGH REFERRAL ARRANGEMENTS OUTSIDE THE NETWORK, AND PROVIDE OUTCOME DATA TO PROVE EFFECTIVENESS.

III. GATEKEEPERS EMPLOYED IN QUALIFIED MEDICARE PLANS MUST:

- Be properly trained for the clinical judgements they are asked to make, e.g. where prior authorization is required for specialty referral or treatment;
- Not have financial incentives to under-treat or under-refer;
- Perform a contemporaneous evaluation of the patient before overriding another physician's clinical judgement; and
- Be accountable for the clinical judgements made in their capacity as gatekeepers.

IV. REFERRAL ARRANGEMENTS MUST BE TARGETED TO PROPERLY TRAINED PRACTITIONERS, ACADEMIC CENTERS, AND "CENTERS OF EXCELLENCE" WHICH SPECIALIZE IN THE TREATMENT OF INTRACTABLE PAIN AND SIMILAR ILLNESSES.

V. MEDICARE FEE SCHEDULES MUST RECOGNIZE THE SCOPE AND INTENSITY OF SERVICES DELIVERED BY PRACTITIONERS WITH ADVANCED TRAINING AND MULTI-DISCIPLINARY TEAMS IN CENTERS OF EXCELLENCE TO PATIENTS IN PAIN WHO HAVE FAILED TO RESPOND TO CUSTOMARY AND USUAL CARE.

July 1995

# JOINT COMMITTEE FOR PATIENTS IN PAIN

## JOINT COMMITTEE FOR PATIENTS IN PAIN

### *THE FACTS ON INTRACTABLE PAIN*

- Pain is a major public health problem in the United States
- **50 million** Americans are partially or totally disabled by pain
- **45%** of all Americans seek care for persistent pain at some point in their lives
- **Headache** and **low back pain** are the most prevalent forms of intractable pain
- Pain accompanies a wide range of other clinical conditions, including:
  - cancer
  - diabetes
  - arthritis
- **22%** of work-related injuries involve back pain
- **150 million** workdays are lost annually to head pain alone
- Children lose **1 million** school days annually due to pain
- Intractable pain is frequently **untreated or mistreated**
- Mismanagement of pain has tragic and costly consequences:
  - disability
  - depression
  - over-utilization of diagnostic services and procedures
  - unnecessary hospitalizations and surgery
- Pain can be effectively treated:
  - with early intervention
  - by appropriately trained specialists
  - frequently in ambulatory settings
  - at reasonable cost

American Pain Society • American Academy of Pain Medicine • American Association for the Study of Headache

## STATEMENT OF PATIENT ACCESS TO SPECIALTY CARE COALITION

Mr. Chairman: This statement is made on behalf of the Patient Access to Specialty Care Coalition ("Coalition"), consisting of nearly 100 patient, physician, and non-physician health care professional organizations dedicated to ensuring the right of patients to consult and be treated at a reasonable cost by the health care provider or specialist of their own choice, regardless of the health plan in which they are enrolled.

As Congress considers changes in the Medicare program to encourage more seniors to join managed care health plans, we believe that several patient protections must be included in any legislative proposal to ensure that seniors continue to be able to access the health care providers of their own choosing.

### THE CORNERSTONE OF THE CURRENT MEDICARE LAW IS CHOICE OF HEALTH CARE PROVIDER

Title 42 of the U.S. Code, Section 1395a clearly states: "Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services."

Proposals to increase the choices of the type of health care plans offered to Medicare enrollees do **not** necessarily ensure choice of health care provider. In fact, they may limit it. In order to encourage people to move into managed care plans, current Medicare enrollees will be required to pay additional copayments, deductibles and out-of-pocket expenses to maintain their current status under Medicare fee-for-service. If the Medicare population enrolls in managed care plans, they will discover that many of these plans may take away their choice of provider and may not permit them to see the health care providers that they have been seeing all along.

The Patient Access to Specialty Care Coalition is proposing a simple quality assurance check on managed health care delivery systems to ensure that patients receive the full range of health care services to which they are entitled, and that patients will continue to have the freedom to choose any health care provider, as currently is provided under the Medicare laws.

### PATIENT CHOICE MUST REMAIN PARAMOUNT IN HEALTH CARE DELIVERY

Many major changes are now taking place in the way people purchase health insurance and receive medical care. The pressures to reduce health spending continue to be intense, and health plans and providers have become more aggressive in their cost containment activities. While many health plans have developed a number of effective techniques to achieve economy and maintain quality of care, others have not always achieved that balance. Since Medicare is a Federal government funded program, we should make sure that these tax dollars result in appropriate patient care.

The Medicare market is open to many different health plans, and there is no guarantee that health care plans would not discriminate against a sicker elderly population. Right now, some health care plans are "cherry-picking" senior citizens by offering aerobics classes, sponsoring "socials," and developing other promotional activities which are targeted at healthy, active Medicare enrollees. Are these added options more choice, or a coercive policy to force seniors into lower cost health care plans which will provide less than the full range of health care services, which are now obtainable under the Medicare program? The most vulnerable population, the elderly, will be flung into a fiercely competitive marketplace where access to appropriate medical services may take a "back seat."

In this rapidly changing health care delivery environment, the Patient Access to Specialty Care Coalition believes that consumers of medical services must have effective protection against the potential that their access to medically necessary health care services will be inappropriately limited.

The most effective check against this potential restraint is the patient's power to seek and obtain medical services outside the provider network established by the health plan. Health plans that provide good service to their enrollees should not be

troubled by this point-of-service feature. Only health plans that fail to meet the needs of their subscribers should be concerned.

SURVEY DEMONSTRATES THAT CHOICE OF HEALTH CARE PROVIDER IS MOST IMPORTANT TO ELDERLY POPULATION

The Coalition had the firm of ICR Research poll a nationally representative sample of Americans age 50 and over on their views concerning Medicare reform (The results of the survey carried a plus or minus 3.2 margin of error). The results of this poll demonstrated that roughly three out of four Americans age 50 and older would not join a Medicare managed care program without the freedom to continue seeing their current doctor or choose a specialist when they became ill.

The poll results indicated that older Americans view their freedom to choose a health care provider as a fundamental personal right that is much more important than other principles, such as the right to bear arms or imposing term limits for Members of Congress.

Eighty-two percent of the respondents said that whether a prospective Medicare managed care program allowed them the freedom to choose out-of-network physicians and specialists would be "critically important/important" to their decision to join one. Even among lower-income seniors (those making less than $15,000 a year), 64 percent said they would choose a Medicare managed care program with the freedom-to-choose feature (for a reasonable co-payment) over a Medicare managed care program that covers the cost of prescription medications. Eighty-three percent of respondents making over $50,000 gave the same response.

The results of this poll are consistent with those released this month by Louis Harris and Associates for the Commonwealth Fund. It found that managed care enrollees were more likely to rate their health plans as fair or poor than enrollees in traditional fee-for-service plans. The polling, which covered families in Boston, Los Angeles, and Miami demonstrated that choice of health care plan and choice of physician were key issues, and that those individuals who were forced into managed care because it was the only health care coverage provided by their employer were twice as likely to rate their plan negatively as those who choose managed care from a list of options.

THE POINT-OF-SERVICE FEATURE

The Coalition is deeply concerned that there are a number of current practices, especially in managed care settings, which impede patient access to treatment, particularly specialty care.

True freedom of choice for patients can only be achieved by making out-of-network medically necessary treatment and services available for all health care plans. All patients should have the option, at an additional but not prohibitive copayment, to seek the out-of-network treatment they desire. This feature should be built into every health care plan, and not just offered at the time of enrollment.

While offering a point-of-service feature at the time of enrollment is a good first step in preserving consumer choice, patients sometimes act with less than perfect information when choosing a health care plan. Many times healthy patients are unable to assess their health care needs, until they actually get sick or need specialty care. Consequently, the broadest possible patient protection is to build choice of health care provider into every health care plan.

Real Medicare reform will maintain the freedom for patients to choose their own health care providers or specialty care provider, and then to continue to access these same caregivers regardless of a change of jobs or health care plans.

As Congress explores the role of managed care in controlling health care costs, it also has the opportunity to guarantee the patients' right to choose, and to make consumers secure in knowing that the health care provider of their own choice will always be there.

Making out-of-network treatment and services available for enrollees in all health care plans provides a very good quality assurance check. It ensures that all health care plans provide the health care that their enrollees need and deserve. The ability of all Americans to seek out-of-network coverage provides consumer protection as well. If a patient is not satisfied with care, he or she could pursue other treatment for a reasonable, but not cost-prohibitive price.

Today, one of the more popular health insurance products among consumers is a closed panel managed care plan with the availability of out-of-network coverage. Patients have been demanding this freedom to choose, and the marketplace has responded. This point-of-service feature for all health plans, therefore, is not intrusive, but rather advances a developing trend, ensuring consistency and predictability for consumers.

THIS POINT-OF-SERVICE FEATURE IS NOT COSTLY

Building a point-of-service feature into all health plans under Medicare will not affect any health plans' ability to be aggressive in their cost containment activities, nor will it limit their efforts to encourage providers and consumers to use health care resources wisely. It will simply put pressure on health plans to keep the patient's welfare uppermost on their agenda, ahead of dividends and the bottom line.

Consumers expect to bear some additional cost for this point-of-service feature. However, this cost is not great, and it is a simple actuarial calculation to determine a reasonable copayment. There is also no financial burden placed on the HMO.

The Patient Access to Specialty Care Coalition retained the firm of Milliman & Robertson, Inc. to study the cost impact on HMOs, if all closed-panel HMOs had to offer a point-of-service to their enrollees. A closed-panel HMO only allows patients to receive care from its own contracted providers. When a closed panel HMO has a point-of-service feature, patients have an opportunity to "opt-out" of the managed care network of providers, and seek "out-of-network" care.

The managed care industry has consistently claimed that a point-of-service feature in all health plans would greatly increase the cost of doing business. This assertion is contradicted by the Milliman and Robertson findings.

According to this study, a built-in point-of-service feature for all managed care plans would not greatly change the cost of managed care or HMO benefits. In fact the study demonstrates that this point-of-service feature, in some instances, can actually lower the costs to an HMO.

The Milliman and Robertson study estimated the "net claim cost" for two typical health care plans in today's marketplace. These plans were developed from existing data in the HMO Industry Study, 1994 of the Group Health Association of America. Milliman and Robertson concluded that when it compared a point-of-service feature to a pure HMO (a closed panel), the expected cost ranged from a decrease of about 5 percent for a typical HMO plan to an increase of about 10 percent for a more generous HMO plan.

Analysis of this data demonstrates that the inclusion of out-of-network coverage within an HMO design does not, in itself, either increase or decrease claims costs incurred by the HMO. Instead, claims costs are increased or decreased depending upon the HMO's selection of factors (deductibles, copayments, and out-of-pocket limits) that encourage or discourage utilization of out-of-network coverage and the nature of the discounts negotiated with network providers. (For the Committees' use, the Coalition has shared a copy of the complete Milliman and Robertson study).

Again, the Patient Access to Specialty Care Coalition maintains that a built-in point-of-service feature provides a good safety valve for the unhappy or dissatisfied members of the closed panel HMO. Under the point-of-service feature, patients are able to go to a non-network provider of their choice. In doing so, however, the patient would incur a higher copayment for the opportunity to go "out-of-network."

This point-of-service feature provides the patient with an out when they question the quality of care they are receiving by the network's limited providers. It also provides an opportunity for the patient to seek an additional opinion from a non-partisan provider when the patient or family disagrees with the decision made by the closed panel HMO or the primary care gatekeeper to withhold treatment or deny an appropriate referral to a specialist.

## EXPANSION OF MANAGED CARE IN THE MEDICARE PROGRAM

The Coalition is not opposed to managed care. It is concerned, however, that Congress may be embracing a concept of cost savings of managed care in the Medicare population without sufficient data.

Should Congress choose to go forward with expanding managed care in the Medicare program, the Coalition maintains that its recommended point-of-service feature will:

a) End the uncertainty and unpredictability of seniors moving in and out of health plans through open enrollment and disenrollment--the feature will always be there, and actuaries could easily calculate utilization of out-of-network services.

b) Give the Medicare patient effective protection against the potential for restricting access to medically necessary health care services.

c) Provide a quality assurance check on all health care plans to make sure that they are providing the full range of health care services to their enrollees.

## THE POINT-OF-SERVICE FEATURE IS NOT AN "ANY WILLING PROVIDER" PROVISION

The point-of-service feature endorsed by the Patient Access to Specialty Care Coalition differs substantially from "any willing provider" proposals. "Any willing provider" provisions deal with the contractual relationships between health plans and providers of medical services. The focus of the Patient Access to Specialty Care Coalition is on patient choice and the health care access rights of consumers and patients.

## THE COALITION IS NOT AGAINST MANAGED CARE, AND WE HAVE TAKEN NO POSITION ON THE REPUBLICAN LEADERSHIP'S PROPOSAL TO EXPAND MANAGED CARE IN THE MEDICARE PROGRAM

There have been several misconceptions about the Patient Access to Specialty Care Coalition. Contrary to comments which have appeared in the press, the Coalition is **not** anti-managed care, and we are not trying to interfere with, or slow-down, the rate of growth in managed care plans. We have not taken any position for or against the House Republican Leadership proposal on Medicare reform. We are not against the gatekeeper concept, and we do not take issue with the important role that primary care providers play in offering quality health care to their patients.

Instead, our message is very simple. We believe that in this rapid changing health care marketplace, patients should be afforded a few basic protections. If the Congress desires to shift the elderly population more toward managed care health care

delivery, all that we asked is that provisions be included to ensure that patient choice of health care provider is preserved, so that Medicare enrollees will be able to continue to have timely access to the full range of appropriate medical services.

OTHER PROVISIONS TO ENHANCE PATIENT CHOICE AND ACCESS SHOULD ALSO BE INCLUDED

The Coalition believes that additional provisions should be included in Medicare reform legislation to enhance patient choice and access. Medicare reform legislation should include: a patient bill of rights ensuring timely access to specialty care; a streamlined appeals process for denial of care or copayment for out-of-network care; a ban on financial incentives which result in the withholding of care or the denial of a referral; and a requirement that health care plans return to patient policyholders, in the form of aggregate benefits provided under the policy, at least 85 percent of the aggregate amount of premiums.

Mr. Chairman, the Patient Access to Specialty Care Coalition's point-of-service feature allowing patients to access out-of-network medically necessary care ensures real choice and real consumer protection, and is a sound quality assurance check to make certain that all plans offer the full range of quality health care.

In your continuing deliberations on managed care and the expansion of managed care in the Medicare program, we urge the House Ways and Means Committee and the House Commerce Committee to ensure adequate patient protection and safeguards in this changing marketplace by instituting a point-of-service feature in all health plans.

A listing of the current membership of the Patient Access to Specialty Care Coalition follows:

(as of 7/7/95)

Organizations in the

PATIENT ACCESS TO SPECIALTY CARE COALITION

Allergy and Asthma Network•Mothers of Asthmatics, Inc.
American Academy of Allergy and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology - Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine & Rehabilitation
American Association for Hand Surgery
American Association for the Study of Headache
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Private Practice Psychiatrists
American College of Cardiology
American College of Foot and Ankle Surgeons
American College of Gastroenterology
American College of Nuclear Physicians
American College of Obstetricians & Gynecologists
American College of Osteopathic Surgeons
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American Diabetes Association
American EEG Society
American Gastroenterological Association
American Lung Association
American Orthopaedic Society for Sports Medicine
American Osteopathic Academy of Orthopedics
American Pain Society
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Rehabilitation Association
American Sleep Disorders Association
American Society for Dermatologic Surgery
American Society for Gastrointestinal Endoscopy
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Pathologists
American Society of Dermatology
American Society of Echocardiography
American Society of General Surgeons
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
American Society of Plastic and Reconstructive Surgeons, Inc.
American Society of Transplant Physicians
American Thoracic Society
American Liver Foundation
American Urological Association
Amputee Coalition of America
Arthritis Foundation
Arthroscopy Association of North America
Association of Subspecialty Professors
Asthma & Allergy Foundation of America
California Access to Specialty Care Coalition
California Congress of Dermatological Societies
College of American Pathologists
Congress of Neurological Surgeons
Cooley's Anemia Foundation
Cystic Fibrosis Foundation
Eye Bank Association of America
Federated Ambulatory Surgery Association
Joint Council of Allergy and Immunology
Lupus Foundation of America, Inc.
National Association for the Advancement of Orthotics and Prosthetics
National Association of Epilepsy Centers
National Association of Medical Directors of Respiratory Care
National Committee to Preserve Social Security and Medicare
National Foundation for Ectodermal Dysplasias
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Osteoporosis Foundation
National Psoriasis Foundation
North American Society of Pacing and Electrophysiology
Oregon Dermatology Society
Orthopaedic Trauma Association
Patient Advocates for Skin Disease Research
Pediatric Orthopaedic Society of North America
Pediatrix Medical Group: Neonatology and Pediatric Intensive Care Specialists
Renal Physicians Association
Scoliosis Research Society
Society for Vascular Surgery
Society of Cardiovascular & Interventional Radiology
Society of Gynecologic Oncologists
Society of Nuclear Medicine
Society of Thoracic Surgeons
The Alexander Graham Bell Association for the Deaf, Inc.
The American Society of Dermatophathology
The Endocrine Society
The Paget Foundation For Paget's Disease of Bone and Related Disorders
The TMJ Association, Ltd.

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